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S. HRG. 101-443

CONSIDERATION OF VA HEALTH-CARE LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

S. 13 (Sections 211, 213-215, and 222-225), S. 165, S. 573, S. 574, S. 748, S. 899, S. 900, S. 947, and S. 1004

MAY 18, 1989

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CONSIDERATION OF VA HEALTH-CARE LEGISLATION

THURSDAY, MAY 18, 1989

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 8:35 a.m., in room SR-418, Russell Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Senators Cranston, Rockefeller, Thurmond, and Jeffords.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. The hearing will please come to order.

Good morning to all of you. I welcome you to this hearing to consider various bills focusing on Department of Veterans Affairs health-care issues. We are very grateful to those appearing today. Testimony will cover a wide variety of subjects ranging from proposals related to furnishing direct health-care services to measures which provide for competitive pay and benefits for professionals furnishing those services.

My detailed opening statement is available at the press table. I'll summarize it briefly now. Even though VA is experiencing a severe budget shortfall which is creating a devastating cutback in services, programs, and personnel, we must continue to forge ahead in our efforts to provide the Department with the tools, flexibility, and authorities needed to furnish quality health care while we are, concurrently, moving forward on the budget and appropriations fronts. We also must continue to monitor the health-care needs of our Nation's veterans and the quality of care we provide to meet those needs.

As the author of S. 13 and S. 947, and co-sponsor of S. 900, I will, of course, be very interested in the witnesses views on these measures, as well as on Senator Murkowski's bills, Senator Thurmond's bill, and those I introduced at the request of the administration. Just this past Tuesday, I introduced for the Administration its proposed health-care measure, S. 1004, transmitted to Congress on May 10.

S. 13 is cosponsored by Senators Matsunaga, DeConcini, Rockefeller, Mitchell, Graham, Burdick, and Kerry. I will highlight briefly those provisions about which we will be receiving testimony today. Sections 211, 213–215, and 225 have as their basic purpose the improvement of various programs of benefits and health-care services for veterans while sections 223 and 224 address concerns involving labor-management relations involving VA and those VA health-care employees employed under the title 38 personnel system.

Specifically, S. 13 includes provisions relating to services to overcome service-connected disabilities affecting procreation, State home construction grants, sharing of specialized medical resources, pilot programs for providing veterans with assistive animals, task force recommendations on the elimination of inconsistencies in certain veterans' benefits laws, and labor-management relations.

S. 900, which Senator Rockefeller and I introduced, would extend for 1 year both VA's authority to furnish respite care to certain chronically ill veterans, and the date by which the Secretary must submit a report on the evaluation of the program.

S. 947, the proposed Veterans Health-Care Personnel Act of 1989, is cosponsored by Senators Mitchell, Matsunaga, DeConcini, Rockefeller, Graham, Inouye, Kohl, Pell, Wirth, and Kerry. It is intended to provide VA the necessary tools, strategies, and flexibility to attract qualified and competent health-care personnel—registered nurses, pharmacists, physical and occupational therapists, and others—in today's competitive marketplace. Reflecting my very strong concern that we must find ways to reduce the Federal deficit, this legislation seeks to find methods to improve VA programs without incurring major new costs.

Both within and outside of VA the problem of recruiting and retaining sufficient numbers of qualified health-care personnel is one which has intensified in recent years. A number of factors have contributed to this problem including, inadequate salaries, increased demand for personnel, poor working conditions, and decreased enrollment in educational institutions which educate health-care professionals. Because the health-care furnished to veteran-patients is largely a function of the quality of the personnel furnishing the care, we must do all we can to enable VA to attract the best and brightest health-care personnel into the system. I believe it's our job to ensure that these men and women who give so much of themselves as they fulfill their daily responsibilities receive respect and support, both because it is right and because it will lead to better health care for veterans who need their attention.

S. 947 would provide VA the authority to be proactive in its recruitment and retention efforts rather than merely reactive. It is designed to avoid counterproductive lag times. If VA had the ability to keep pace with rates paid in the community, I believe that greater numbers of health-care professionals would seek out VA as an employer and the expensive and demoralizing staff turnover would be significantly decreased.

To reverse this trend and to provide VA the tools to respond quickly to community conditions, S. 947 would require the Secretary to establish and maintain levels of competitive pay for full- and part-time RNs and authorize the Secretary to establish and maintain levels of competitive pay for other health-care employees covered by title 38 for pay purposes only. The pay rates would be competitive with but would not exceed the pay of employers offering similar employment and competing in the same labor-market area for qualified employees.

This measure would require each director of VA health-care facilities to perform an annual survey, no later than June 1, 1990, and on December 1, 1990, and each December 1 thereafter, of basic entry wages paid in comparable facilities within their labor-market areas, and then to establish or adjust competitive pay rates.

Other provisions in S. 947 deal with overtime payments for RNs, RN specialty recertification, exemplary performance cash awards, dependent care assistance programs, waiver of military retirement or retain pay for VA health care professionals, special salary rates, employment of VA-trained personnel, assistance to health personnel education institutions, health professional scholarship awards, pilot program on pay and personnel management practices, and leave sharing.

A number of the provisions were passed by the Senate one or more times in the past, but were not accepted in the House. We will keep trying.

There are obviously a great number of bills to be discussed today that are designed to improve the health care furnished to our Nation's veterans. The members of our committee are very interested in the ideas and views of those appearing before us today, as well as those who have submitted written testimony. I, again, want to thank all the witnesses for their participation and help on these important matters.

Before proceeding with our first witness, I want to note again that since we have many witnesses today and limited time, we ask each witness to limit his or her oral testimony to 5 minutes so that we will have sufficient time for questions. We'll be using the lights that are here this morning. When you see the yellow light you have 1 minute remaining on your time. When you see the red light and hear the bell, your 5 minutes have expired, so please then conclude your remarks.

We've asked all witnesses for prepared statements, which will of course, be printed in full in the hearing record. We've received, or will be receiving, written testimony from the following organizations which will not be appearing this morning: Helping Hands, Inc., the National Association of State Veterans Homes, and the Medical University of South Carolina.

Also I want to note, that I will be asking some witnesses to submit written testimony by June 2 on S. 1004 which I introduced last Tuesday at the administration's request.

I want, now, to welcome our good friend, Tony Principi, to his first hearing before our committee as Deputy Secretary of Veterans Affairs. Welcome also to Chief Medical Director, Dr. John Gronvall, and VA General Counsel, Don Ivers. Vernice, it's always a pleasure to have you with us. Because so much of the legislation introduced has a great impact on nurses, your testimony here today will be particularly welcome, and I'm sure informative. I also welcome Ronald Cowles, who's here today representing the Office of Personnel and Labor Relations.

Thank you all for coming so early this morning. Tony, as you know, we'd appreciate your keeping your oral statement to the 5 minutes that I mentioned. Thank you.

[The prepared statement of Chairman Cranston appears on p. 126.]

STATEMENT OF HON. ANTHONY J. PRINCIPI, DEPUTY SECRETARY OF VETERANS AFFAIRS, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR; VERNICE FERGUSON, DEPUTY ASSOCIATE CHIEF MEDICAL DIRECTOR FOR NURSING SERVICE; RONALD E. COWLES, DEPUTY DIRECTOR, OFFICE OF PERSONNEL AND LABOR RELATIONS; AND DONALD L. IVERS, GENERAL COUNSEL

Mr. **Principi**. Thank you, Mr. Chairman.

It is indeed a pleasure to be with you and members of the staff to present the Department's views concerning legislative initiatives on your agenda. With me are members of our senior team, Dr. John Gronvall, Chief Medical Director; Don Ivers, our General Counsel; Vernice Ferguson, our Deputy Assistant Chief Medical Director for Nursing Programs; and Ron Cowles, our Deputy Director of Office of Personnel and Labor Relations. Unfortunately, Mike Rudd could not be with us today, because of a family matter.

Mr. Chairman, there are numerous proposals on today's agenda, a number of which the VA supports. There are other meritorious provisions regarding the recruitment and retention of nurses, which we ask be held in abeyance for a short time pending completion of a VA task force study.

We have submitted a detailed statement that discusses each of these proposals and the basis for VA's positions on these provisions. With your approval, I will comment briefly on selected issues, and request that the VA's full statement be made a part of the hearing record.

Chairman **Cranston**. That will be fine.

Mr. **Principi**. Thank you.

A major portion of today's agenda deals with personnel management issues and proposals aimed at helping us recruit and retain a highly qualified health-care work force. We very much appreciate the committee addressing these issues. Maintaining a quality health-care work force is critical to our Department's ability to accomplish its mission to provide quality health-care services.

In this regard we support many of the proposals that you have introduced, including discretionary authority to permit Saturday premium pay for nursing assistants; authority to hire retired military health-care professionals, without the requirement that their retirement pay be reduced; raising the special salary rate cap in circumstances where VA medical centers are paying 90 percent or greater of the maximum allowable rate; establishment of a dependent care assistance program; authority to appoint graduates of VA-affiliated allied clinical health-care education programs, without regard to competitive civil service procedures. We also support the concept of providing cash awards for exemplary performance to title 38 employees, both supervisors and nonsupervisors.

Mr. Chairman, your bill would completely restructure the pay system for VA's registered nurses, nurse anesthetists and other health-care positions that the Secretary determines should be brought under the new system. Although the proposal contains features which we do support, such as greater pay flexibility and greater decentralization of the pay setting process, regretfully, we find it difficult to support your proposal as drafted.

As you are aware, a VA nurse pay task force has developed ideas for restructuring the nurse pay system. Those ideas along with proposals to lift caps on overtime pay and special rates, and provide additional pay to head nurses are currently being reviewed within the Department. We would request that the committee defer taking action for a short time on these proposals, until we can put forward our own proposals and will do so, if possible, outside the normal legislative cycle. We are not asking that they be deferred as a way of delaying action, but we feel that we may have some very positive recommendations to make to you in the construction of that task force.

Mr. Chairman, section 223 of S. 13 would significantly change the character of the title 38 system of employment by bringing clinical and professional matters that affect the quality of health care in VA facilities within the purview of collective bargaining requirements of title 5 of the United States Code. We cannot support your bill.

Mr. Chairman, the Department is strongly committed to continuing the long-standing practice of handling clinical and professional matters that directly affect the quality of care through the established medical peer review process. Medical peer review procedures provides for the review by medical professionals of the quality and utilization of medical care services. This process relies on the judgment of persons trained in medical care, and in so doing promotes the delivery of quality medical care services.

The VA has been so strongly committed to the peer review principle, that for many years it has aggressively defended this position in litigation. The litigation with strong Department of Justice support, culminated in the Colorado Nurses case decision, which supports our interpretation of current law. We strongly oppose this provision.

Section 224 includes modifications to our current disciplinary procedures for title 38 employees. We have been seeking these changes for a number of years. However, the Department cannot support this provision because it also includes a right for collective bargaining over clinical and/or professional matters. The Department would recommend, as an alternative, the approach taken in S. 1136 and H.R. 2009, bills that were introduced in the 100th Congress.

Mr. Chairman, in addition to recruitment and retention of health-care personnel, today's agenda includes other important issues which I will comment on briefly. We have provided financial support for research which has sought to demonstrate that trained monkeys may assist spinal cord injured persons in carrying out certain tasks. We are nearing conclusion of an evaluation of the research project of Dr. Willard, a project we have helped fund for some time, to determine its potential benefit for veteran patients. Until that determination is completed, however, we don't believe it would be appropriate to endorse either of the provisions on today's agenda regarding simian aides.

We support enactment of S. 573 with modifications that would return a portion of funds collected from third-party payers to the

VA medical facility providing the service, and allow the VA to contract for collection services using the proceeds.

Chairman CRANSTON. Tony, because this is your first hearing, we'll give you 2 more minutes. But we won't always be so generous. [Laughter.]

Mr. PRINCIPI. Thank you, Mr. Chairman.

Although the goals of your proposal to provide certain procreative services to veterans who have a service-connected condition which prevents or impairs their ability to conceive a child is most laudable, we cannot support the proposal at this time for the reasons described in our formal statement.

Finally, Mr. Chairman, we want to thank you for including many of our legislative proposals on today's agenda. We urge enactment of those provisions. Mr. Chairman, there are other important issues on today's agenda. In the interest of time, I will conclude my comments by saying thank you, and we are prepared to answer any questions regarding the proposals before us.

[The prepared statement of Mr. Principi appears on p. 141.]

Chairman CRANSTON. Thank you very much.

Senator Thurmond, do you have any remarks to make at the outset?

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Mr. Chairman, I have an opening statement I would like to make.

Mr. Chairman, it is a pleasure to be here this morning to address what many consider to be the number one veterans-related issue across the country—quality health care. Mr. Chairman, I am pleased that you have scheduled this hearing, and that we will be considering such matters as the State nursing home grant program, the respite care program, dental care, nursing recruitment and retention, and many other related issues.

I am especially pleased that you have included on the agenda a bill I introduced earlier this year, S. 165, which authorizes the joint construction, ownership, management, and use of a state-of-the-art medical research facility by the Department of Veterans Affairs and the Medical University of South Carolina. This venture provides an exciting opportunity to combine the talent and resources of a Federal department with a proven educational institution.

Although the Department of Veterans Affairs and other organizations have announced their opposition to this proposal, I remain convinced that joint Federal/State ventures of this type represent a wise use of Federal resources. I do not believe that this proposal is incompatible with processes aimed at assuring equitable distribution of VA health-care resources. Instead, Mr. Chairman, this is a venture which will provide far-reaching benefits to all the veterans of this country, not just veterans of one region. Additionally, I want to emphasize again, this is a center dedicated to research.

As we enter the decade of the nineties, more than 7.7 million veterans will be in the over-65 age category. This legislation will directly benefit this category of veterans by providing state-of-the-art research into the causes and treatment of diseases such as chronic heart disease, Alzheimer's disease, diabetes, arthritis, and many others.

Mr. Chairman, the Governor of South Carolina endorses this legislation, and the State of South Carolina, in conjunction with the Medical University, is committed to providing $12 million for the center, which is one-half of the construction costs. In fact, the South Carolina General Assembly has already allocated $500,000 for the architectural/engineering design phase of this project. In addition, the Medical University will provide the land for the construction of this center.

Mr. Chairman, I might also point out that this center would free up space in the existing VA medical center in Charleston. Existing research which is conducted at the medical center would be transferred to the new research center, thereby increasing by approximately 10 percent the critical care bed availability.

To sum it up, this legislation provides an excellent opportunity for the Federal and State governments to work hand-in-hand on an endeavor that has far-reaching benefits for all veterans in this country.

I appreciate the opportunity to offer my comments on this legislation. Dr. James Edwards, the President of the Medical University, and former Secretary of Energy from 1981 to 1982, is unable to be with us today because of a Board of Trustees meeting at the university, but he is pleased to submit written testimony, which the Committee has already received.

Mr. Chairman, in closing, we must continue to see that all health-care challenges facing the Department of Veterans Affairs are met in a reasonable and appropriate fashion. I look forward to reviewing the testimony on all the issues to come before the committee today. I must leave in a few minutes for another meeting.

Now, I want to say further, Mr. Chairman, and especially to Mr. Principi, that I talked to the Secretary of Veterans Affairs last night. And somebody over there is turning it down—well, this hasn't been brought to his attention. He didn't know anything about it. Now, a matter as important as this, I feel, should be acted upon by the Secretary. He was very interested when I told him about it, because of what the State's putting up here—$12 million, a site, and the research has got to be done somewhere. And where else have you got an offer of that kind?

And I'd please thank you, to take this up with the Secretary, because he said he wanted to do that with you.

Mr. PRINCIPI. I shall, Senator.

Senator THURMOND. And he said he'd certainly consider it. And we'd appreciate it very much if you all would do that.

Mr. PRINCIPI. I will.

Senator THURMOND. Thank you.

Chairman CRANSTON. Thank you, Strom.

Senator THURMOND. Thank you.

Chairman CRANSTON. Tony, unless I specify otherwise my questions will be directed to you, but if you want to refer them to any other person at the table with you, don't hesitate.

Mr. PRINCIPI. I appreciate that.

Chairman Cranston. We have a lot of ground to cover. I would appreciate all of you keeping your answers as brief, and yet, as responsive as you can.

First, Public Law 100–322 required VA to study and submit a report to both the Senate and House Veterans' Affairs Committees by May 19, 1989, on the effects of certain pay and personnel management practices including flexible benefits, pay compression, and shift differentials. On page 29 of the VA testimony it is stated that any support for pilot programs in these areas must await completion of a review of the study which has been performed by an outside contractor. When can we expect that report?

Mr. Principi. I think you'll have that report by July 31 of this year.

Chairman Cranston. Thank you.

On page 33, VA proposes, for the first time, that 50 percent of receipts collected through third-party reimbursement be "legitimately", whatever that means, retained in the VA. I want to make clear that I would favor an approach that would give your local hospitals an incentive to do a better job on third-party collections. But previously VA has been opposed to such a provision because of the real concern, which I share very strongly, that the funds collected would not be a source of additional support for the VA health-care system, but rather, if VA were authorized to retain those funds, VA budget requests and appropriations would be reduced by OMB by an amount equal to the amount anticipated, to be collected. Because OMB consistently overestimates the amount of third-party reimbursements to be collected, OMB would have the power to bring about a decrease in VA's overall budget by projecting greater amounts of collections than VA would actually receive.

For example, the OMB estimate of third-party payments for fiscal year 1990 is $304 million while VA's own estimate of these payments is only $136 million. Under this scenario, if VA were to collect the amount it projects, total VA funds available for health care for fiscal year 1990 would be decreased by $168 million.

Tony, what does "legitimately" mean and what assurances have you received from OMB which have led you to believe that OMB would not decrease the VA budget request by the amount projected to be collected, or reject or reduce subsequent supplemental requests in light of the amount allegedly to be collected?

Mr. Principi. Mr. Chairman, in my view "legitimately" means that there will be no offsets, that we will be allowed to retain those dollars. With regard to the estimates of the amount of receipts we'll receive in any given year, we will certainly strive to collect as much as possible. I don't know whether we will achieve the more than $300 million estimate, however, we will certainly attempt to achieve that level.

We will take our case to the Office of Management and Budget. We will seek fair estimates, and we will seek to retain those dollars without any offsets. I don't have any assurances, per se, however, I can give you my word that we intend to strive for no offsets and use these dollars as an incentive to increase our third-party collections and keep those dollars at the VA medical centers.

Chairman Cranston. You do not have any assurances from OMB, however, do you?

Mr. PRINCIPI. I have assurances in the sense that they agreed to the words, legitimately retained. And I take that at face value. And I don't want to second guess them or prejudge them. I believe that they see the merit in allowing us to keep those dollars as an incentive to increase our third-party collections. And I believe we can work with them and we can take it on a year-to-year basis and see if this can work. I think it deserves a chance.

Chairman CRANSTON. Do you have an explicit understanding with them that their interpretation of "legitimately" is the same as your interpretation of "legitimately"?

Mr. PRINCIPI. We've had a great many discussions over the word legitimately. And I hope we have the same definition of the word.

Chairman CRANSTON. You agree on the word, but you don't necessarily agree on a common interpretation of that word.

Mr. PRINCIPI. I believe that there's a common understanding, and that's the way we're going to proceed.

Chairman CRANSTON. I really think it's a very risky business. I think you should get it nailed down, explicitly.

Mr. PRINCIPI. We've come a long way, Mr. Chairman, and I believe they do see the merit in allowing us to retain those dollars above and beyond what would be normally allocated to that facility, to encourage third-party collections.

Chairman CRANSTON. Under your proposal, would you allow the VA share of the dollars collected to be retained in full at the local VA facility?

Mr. PRINCIPI. That's an issue we need to look at very carefully to ensure whether those resources need to be retained at that facility, or perhaps to other facilities. It would be my hope that the facility, if we're going to provide an incentive for a facility to collect third-party dollars, that the funds collected should stay at that facility.

Chairman CRANSTON. They really need some incentive.

Mr. PRINCIPI. Exactly. And that's the whole purpose of the retention.

Chairman CRANSTON. What would you think of the following alternative: Have Congress legislate the 50-percent policy 1 year at a time and then have VA witnesses testify under oath after each budget request is submitted whether or not there was a reduction by OMB for the current fiscal year before Congress decided whether to reextend this policy for another year?

For example, let's say we passed a law directing VA to keep 50 percent of the collections for fiscal year 1990; then, next February after the fiscal year 1991 budget is submitted, we evaluate what happened and decide whether to extend the 50 percent retention provision for fiscal year 1991, and so on thereafter? How do you think that might work?

Mr. PRINCIPI. I believe that's a viable approach and has great merit. I don't believe there's any necessity to have the witnesses testify under oath. I can assure you that no one on our team is going to mislead this committee, and they're going to speak honestly with regard to these matters. They're too important. But I do believe that approach has great merit, and we'd like to work with your staff on it.

Chairman CRANSTON. Fine. Let's try that then.

In regard to the oath, we've now followed the practice for 2 years, during budget hearings, to put everybody under oath. We will be continuing that practice. But it wasn't directed to this particular matter.

As you would expect, I was disappointed about VA's position in its prepared statement on several of the legislative proposals, particularly the provision on procreative services and Colorado Nurses.

On procreative services, my impression has been that you personally supported VA providing these services to veterans and their spouses. This is the third time VA has testified against this provision, and I had hoped for a change given the new leadership at the Department. Would you please continue to review this area and see whether some VA movement might be possible on that issue?

Mr. Principi. Yes, Mr. Chairman, we will certainly review our position. I know the Secretary believes that we want veterans, service-connected disabled veterans, especially those who have borne the battle, to have available to them every advance and medical technology available to us. There are very complex and troubling questions regarding this issue which we're grappling with, but we'll continue to work with Dr. Gronvall and others at the Department, and review that position. You know what my personal position is on it.

Chairman Cranston. On the labor relations provisions, VA's testimony seemed very antiunion, frankly. As you know, I'm quite concerned about the status of VA management and labor relations in the wake of last year's decision in the Colorado Nurses case and I continue to hope that we can all work together to find a satisfactory resolution. VA's written testimony clearly states VA's "strong" opposition to section 223 of S. 13, which would make chapter 71 of title 5 applicable to title 38 employees, and section 224, which would establish a procedure for lesser grievances. VA's opposition seems based on the concern that the two sections negate the peer-review process to which VA has been committed over the years and the fact that VA won in the Colorado Nurses decision. The VA's position raises a number of questions, I think.

First, shortly after Colorado Nurses was decided, and numerous times since then, VA has asserted that it will maintain the prior status quo, that is, the continuation of collective bargaining on the working conditions of title 38 employees, while all parties attempt to negotiate a permanent solution in the wake of the Colorado Nurses decision. Despite a number of assurances that VA will continue with the status quo, the committee has received some reports of VA officials refusing to bargain with labor unions. For instance, the National Federation of Federal Employees, on pages 6 and 7 of its written testimony, presents instances where VA management at the Northport, NY, VAMC has refused to bargain with NFFE Local 387 regarding working conditions. I understand that similar refusals have taken place in Togus, ME, and Fargo, ND. Tony, if NFFE or any of the other unions provide you with details of any such refusals, may I have your assurances that you will look into those instances, and get back to the committee with your findings?

Mr. Principi. You have my assurance, Mr. Chairman.

And if I just might add a point or two—perhaps Mr. Ron Cowles can speak to some specifics. I'm sorry you characterize our testimony as antiunion. Speaking for the Secretary, he certainly is not antiunion. He believes that the unions play a very, very important role, and an appropriate role.

Chairman CRANSTON. Well, let me say that I know that neither you nor the Secretary are antiunion. But the testimony seemed to be that way.

Mr. PRINCIPI. The Secretary has also made it very clear that he intends to honor our collective bargaining relationships, notwithstanding the Colorado Nurses decision, at least during this interim review period, and that we will work with the committee on this very troubling and sensitive issue.

May I defer to Mr. Cowles, perhaps to address some of the issues that you raise with regard to specifics?

Mr. COWLES. Thank you.

We are very interested, as Mr. Principi has added, in being able to work with all parties, including those organizations representing employees, to fashion something that will, in fact, balance the interests of both the employee organizations and VA in maintaining VA's quality care and peer review, and protecting from third-party litigation clinical issues having to do with the delivery of care. At the same time we want to recognize and bargain in limited areas involving those which are traditionally found in labor-management relationships that do not interfere with the Secretary's ability, or the Chief Medical Director's to provide basic care. I think it's achievable. We need some time to work with the committee and those organizations in fashioning what that relationship might be in the scope of bargaining under that kind of a relationship.

Chairman CRANSTON. I understand the VA's concerns with regard to section 223 are based on the possible destruction of peer review, which I understand to mean peer review in the context of decisions concerning quality of care issues. I really don't understand that concern because section 224 specifically provides a peer review procedure. Why would VA object to providing as to other matters, not involving clinical care issues, rights to bargain that are similar to those available to other Federal employees as long as the law provides for peer review when quality-of-care issues are involved?

Mr. COWLES. I'd like to address that. The way that section is currently written, it would address those instances in which disciplinary action, lesser forms of disciplinary action, are being appealed, which involve matters related to patient care. And it provides a process whereby a third-party arbitrator not disciplined in healthcare matters would review that appeal. However, it does not appear to provide the same kind of protection in other clinical matters where discipline has not been taken. For instance, in the area of clinical privileging we've had some history in our bargaining relationship where physicians have in fact filed grievances over unfair labor practices, or the revocation of clinical privileges.

Here's an area where the VA would have sought to limit, for instance, in the surgical area, what a surgeon might be able to perform, given concerns about their performance. We've had instances where a review of those actions have been subjected to third-party litigation. We're concerned that the way the grievance procedure is being fashioned in this legislation, it would allow that kind of an issue to be addressed, and that the VA could be directed, perhaps in some cases, to restore those privileges, not in the interest of the program or providing care, but because someone feels, perhaps, that certain procedures weren't followed in that revocation. In addition, when talking specifically about those areas where a person is appealing some discipline, some of the discipline clearly is related to patient care delivery, medication errors, minor patient abuse, and the like. Even with an arbitrator schooled in health-care matters, we're talking about an individual who is not attuned to the VA system, its mission, its unique care environment, and we would prefer to see a system in which VA is allowed to have a process where employees have full due process, but where those decisions are being made by people that are within the VA system, peers of those individuals, to decide whether or not the discipline was appropriate for providing care that was inadequate.

Chairman CRANSTON. But your main concern is clinical privileges?

Mr. COWLES. Clinical issues, patient care matters, but certainly clinical privileges is a very strong consideration.

Chairman CRANSTON. John and Vernice, I'd like to address this question to each of you. Would you comment on what effect failure to achieve some favorable outcome on the issues raised by sections 223 and 224 will have on your current recruitment and retention problems?

John, do you want to start?

Dr. GRONVALL. I'm sorry. I think I don't understand exactly what the question is when you say failure to achieve a favorable outcome.

Chairman CRANSTON. If we don't resolve the union representation point, what problems will you have with recruitment and retention?

Dr. GRONVALL. I don't see a direct link at the present time. We have policies and procedures regarding the appointment of professionals. We don't believe there is a problem that needs resolution at the present time on that issue.

Chairman CRANSTON. The unions, in their testimony, and the nurses' representation in their testimony, think it will provide difficulties with retention.

Let's hear from Vernice.

Ms. FERGUSON. At this moment, I think almost anything is fair game for a struggle in terms of recruitment and retention, and hence, I think there's need, as we have said, the Secretary would look at these issues to explore. At this moment, I am not sensitive to any major issue that arises that would make this the largest determinant of a recruitment or retention issue. I would not deny that this may well be a concern in some settings.

Chairman CRANSTON. It may not be the largest issue, but it does exacerbate the situation, and we don't think we can afford to do any more of that.

Senator Jeffords, do you have any questions?

Senator JEFFORDS. Yes, I do, Mr. Chairman. Thank you.

It's a pleasure to be here today, and to be able to ask you some questions.

First of all, I was very pleased with the decision of the Secretary not to appeal the Agent Orange decision of the courts. I would like a little information as to what the plan is for providing regulations consistent with the court's decision, and whether there's any time schedule which you could reveal to us at this time?

Mr. PRINCIPI. Senator, we're in the process of rewriting the regulations to comply with the court's decision. We hope to have them done in the very near future, within the next few months, perhaps early fall.

We shall make contact with the Advisory Committee to get them to review the literature in light of the new standards, as enunciated by the court. They're not going to be reading new literature, they're going to be going over the same studies that they've looked at. Then based upon their recommendations under this new Standard of Significant Statistical Association, we will issue new regulations implementing those recommendations. So it's a two-phased process. We're going to issue two sets of regulations. One will establish the new Standard of Significant Statistical Association and benefit of the doubt, putting aside the cause and effect relationship. And we hope to have that done—the Secretary has said October 1, 1989. Then we'll issue new regulations if the Advisory Committee, in fact, find an association between certain diseases and Agent Orange.

Senator JEFFORDS. Not later than, or hopefully by?

Mr. PRINCIPI. If the Secretary says October 1, I sense it will be October 1.

Senator JEFFORDS. Thank you.

Written in this morning's Washington Post is an article on the proposed House version which would provide $340 million in supplemental appropriations. That money would ensure funding for certain construction programs. And I think it mentioned New Orleans, and Saginaw. Do you believe it's appropriate to spend money which is so urgently needed to maintain the health-care programs out of that supplemental on construction, and if so, why?

Mr. PRINCIPI. I believe it's appropriate. Most of the dollars in the supplemental will go for patient care, to maintain staffing levels, to help us alleviate the backlog of equipment that we desperately need for our VA medical centers. But we also need to renovate and modernize a few of our facilities to ensure that we have quality of care. The amount of money for construction, I believe, is $85 million—is a small percentage of the total supplemental. We're trying to have a balance——

Senator JEFFORDS. Are these ongoing projects that construction would have to stop in the midst of contracts, or are these new things which are being started up with that money?

Mr. PRINCIPI. I think I have to provide that, but my understanding is that these are not new projects. These are projects that are ongoing in some phase of construction.

But I will certainly provide that information.

Senator JEFFORDS. Well, I could see some sense to that, if it's a question of continuing something rather than stopping it because then you'd probably had to redirect other funds perhaps in order to keep those going to maintain contracts. But I would hope it's not new construction and new starts.

Mr. **Principi**. I don't believe it's new construction. As Dr. Gronvall reminds me, some of that money is for activations in the final stages of completion so that we can activate those facilities.

Senator **Jeffords**. I appreciate that answer.

Some of the service organizations have expressed some concern with S. 573, of which I'm a cosponsor. They've raised a number of issues. I wonder if you could give us your view on those. They talked about—this is a third-party reimbursement—they've mentioned inconvenience to veterans and discouraging veterans from using the VA health-care system, and eventually dismantling the system, wreaking havoc on the system. I don't understand their assertions, but I would appreciate it if you have any comments or can enlighten me as to whether there are legitimate aspects to their concerns.

Mr. **Principi**. Senator, we certainly will look at all of the concerns of the service organizations. We do not want to wreak havoc or discourage service-connected veterans, or any veterans, from using our system. We do believe we have a top flight medical——

Senator **Jeffords**. I'm talking about the bill, S. 573, that would allow collections of third-party reimbursement?

Mr. **Principi**. Right. Well, I don't believe by imposing third-party reimbursement that we're going to discourage anyone from using our system or create any inconvenience. What we're saying is, that if a veteran has a non-service-connected disability and is being seen in our facilities, and that veteran does have insurance, employer insurance, or health insurance of some type, then in an era of enormous fiscal constraint, we'd like to have the ability to collect that money from the insurer so that those dollars can stay at that VA medical center so that we can do more than we are currently able to do in this era of fiscal constraint. We think it does make good sense. Again, no service-connected veteran will have to take any money out of his pocket. This is just if they have insurance and we are capable of collecting those funds, and pouring them back into our system.

But we will look at it carefully to ensure that it's not having any unintended side effects. And we'll adjust it accordingly.

Senator **Jeffords**. Thank you very much. Thank you, Mr. Chairman.

Chairman **Cranston**. Thank you.

Senator Rockefeller, Jay, do you have any opening statement or questions?

Senator **Rockefeller**. Mr. Chairman, I'm hesitant to walk in half an hour late, an hour late, and give an opening statement, but if I said something nice about you, would that help?

Chairman **Cranston**. Yes. You have full authority to speak. [Laughter.]

OPENING STATEMENT OF SENATOR ROCKEFELLER

Senator **Rockefeller**. Good morning, everybody. I'll just take a second.

I'm really pleased, Mr. Chairman, about the way you are handling the VA health-care crisis. I've been on the Veterans' Committee for more than 4½ years now, the crisis is real. By 1990, there's going to be 1 out of 4 veterans 65 years or older, by 2000, 1 out of 3. The VA is being downsized, so-to-speak, because of OMB-initiated cuts. In effect, the OMB has effectively managed to ration care to our U.S. veterans. Chairman Cranston, you've been a true leader in fighting for the decent medical care that our veterans deserve. I am glad to be participating with you.

Frankly, I'm very heartened by the current administration. I think that we see a willingness to recognize the proportions of the dilemma that we're trying to deal with, by working with the Congress in trying to get a supplemental appropriation passed as quickly as possible. I have great hope we can work with the new administration. I strongly supported Mr. Derwinski's nomination. I think the President has surrounded himself with very good people.

I think it's incumbent upon us on the Veterans' Committee to look for new and creative ways to help. I am concerned about the lack of long-term health care, in general, for our country, and especially for veterans. Lack of long-term care coverage is a horrendous problem. There are, I think, several options out there and I will be exploring these options as a member of the Bipartisan Committee on Health Care.

I want to speak for a moment, Mr. Chairman, about S. 900, which I feel very strongly about. Respite care gives families a temporary break from caring for chronically ill veterans. In Beckley, WV, 12 veterans and their families have received respite care services. I want to see the respite care program grow. What we're talking about is giving care to the caregiver, giving respite. I am very pleased that both you and the ranking member, Senator Murkowski, have included provisions in bills that also contain respite care provisions.

I apologize for my late entrance. I have some questions which would be appropriate, or inappropriate at this point?

Chairman CRANSTON. Go ahead.

Senator ROCKEFELLER. I'm getting everything I want this morning.

Chairman CRANSTON. After your great achievement on the budget resolution, when you obtained funds to be allocated for VA medical purposes, I wanted to congratulate you on that.

Senator ROCKEFELLER. I want to thank you for your support. I understand the House accepted a similar amendment.

Chairman CRANSTON. Taking care of it in a major way. And you've been very helpful.

Senator ROCKEFELLER. In West Virginia, only the Beckley VA Medical Center has a respite care program. We have four veterans hospitals, and my question, Tony, is who determines, and how is it determined whether or not a VA hospital offers respite care? Dr. Gronvall, perhaps you want to answer that one.

Dr. GRONVALL. Thank you, Senator Rockefeller. We have a set of program guidelines that define the respite care programs that we operate. Individual medical centers then develop a proposal to have a respite program. We review that in Washington, and if it meets the guidelines and the criteria, we approve it.

I think at the present time something like 90 of our medical centers have the programs. They're relatively new in the VA. Our experience to date is very positive, in exactly the way that you describe. These programs can give a real boost, both to the veteran and to the people at home who provide care for the veteran, and can assist veterans in staying at home for a longer period of time rather than needing to be in the hospital, or nursing home. So we support the program. We had introduced a proposal to extend it for 2 years. We're working on more formal evaluation of it, but we believe it's a very desirable program.

Senator **Rockefeller**. Who makes the decision, once again?

Dr. **Gronvall**. Well, the individual medical center requests the establishment of a program. The decision is made in Washington as to whether their program meets the guidelines that we've established for them.

Senator **Rockefeller**. Good, thank you.

Chairman **Cranston**. Thank you very much, Jay.

Tony, I just want to say I join in Senator Jeffords' favorable comment on your actions on Agent Orange regulations. I've just signed a letter to Ed congratulating him for the outstanding action that he took.

Back to the questions I wanted to put to you. Do you have any information on the practices within the private sector with regard to the use of collective bargaining with respect to health-care professionals? What I mean by that is, the number of health-care facilities that currently have such collective bargaining, and so forth.

Mr. **Principi**. I don't believe we have that information, but I'll defer to Mr. Cowles.

Mr. **Cowles**. We are aware that there is, in fact, collective bargaining relationships in the private sector. We can, however, furnish you information on the extent of that for the record.

Chairman **Cranston**. Please do that. It's very widespread, I gather.

Mr. **Cowles**. Yes, it has been a growing phenomenon. There are nurses, for instance, that are covered under collective bargaining relationships.

Chairman **Cranston**. Can you get us that material by June 1?

Mr. **Cowles**. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Our research indicates that the requested data on health care professionals as a category apparently is unavailable on a nationwide basis. However, the Bureau of Labor Statistics (BLS), U.S. Department of Labor, reported that as of May 1980, 14.9 percent of employed hospital workers and 7.4 percent of workers employed in the medical industry, excluding hospitals, were represented by unions. (BLS Bulletin 2105, "Earnings and Other Characteristics of Organized Workers, May 1980")

With respect to registered nurses, the "Report of the Hospital Nursing Personnel Survey," published in 1987 by the American Hospital Association, indicated that the percentage of hospitals which reported that their registered nurse staffs were organized for purposes of collective bargaining increased from 12.9 percent in 1985 to 14.8 percent. According to the same report, 19 percent of non-Federal Government hospitals had registered nurse bargaining units. A copy of the pertinent portion of that report is enclosed.

Additionally, BLS Bulletin 2273, "Industry Wage Survey: Hospitals, August 1985," reported the number of general duty nurses covered by labor-management contracts in certain hospitals in selected metropolitan areas. A summary of the BLS data is attached.

[The report and BLS data appear on p. 174.]

Chairman **Cranston**. Thanks.

Tony, as you and Ron have already proposed, then, we'll schedule meetings with VA staff, committee staff, and yourself so that a satisfactory accord can be expeditiously reached on sections 223 and 224. I'm delighted that you're amenable and open to seeking such an accord.

On page 22 of the VA testimony, it is stated that, if a cash award program were enacted, sufficient time would be required to establish an incentive award program. How much time would be needed to implement such a program?

Mr. **Principi**. Approximately 6 months, maybe more. We'd have to get a good look at that.

Chairman **Cranston**. John, I've been interested in the evaluation of the capuchin monkey program. I understand it's just been completed. Can you get us a report on that by the end of the month?

Dr. **Gronvall**. We hope to provide Department views on the pending legislation on this subject by June 30.

Chairman **Cranston**. Thank you.

Tony, on page 11 of your testimony, you state that costly dental reexaminations could be avoided if VA increased from $500 to $1,000 the amount which a fee-basis dentist could charge without obtaining a VA examination.

Under the current $500 ceiling, what percentage of proposed fee-basis plans are denied?

Dr. **Gronvall**. Mr. Chairman, we deny very few plans, practically no plans are denied. The plan is submitted, it's reviewed, and the patient has a second examination, and our experience to date has been that essentially none of the proposed treatment plans must be denied.

Chairman **Cranston**. The fact that dentists know there may be a reexamination can have some negative impact on how much they undertake?

Dr. **Gronvall**. Yes, I think that certainly is a factor. And that is generally pointed to as one of the basic reasons in any situation, for having a second review, or a second opinion.

Chairman **Cranston**. How many requests are made annually for such a VA examination?

Dr. **Gronvall**. Well, we have about 11,000 veterans that have to have a second opinion because of the $500 limit each year.

Chairman **Cranston**. What would be the increased cost of doing dental work if dentists were free to charge up to $1,000 without VA confirmation of the necessity for the proposed work by its own examination?

Dr. **Gronvall**. I don't know that we have a figure at our fingertips on that. I think we need to review that and supply a response for the record.

Chairman **Cranston**. Doesn't it follow, though, there would be some increase? I don't think you're taking that into account in your cost estimates.

Dr. **Gronvall**. Let us take another look at that—that factor specifically, and reply for the record.

Chairman **Cranston**. Fine.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

There would be no increased cost to provide dental treatment if the threshold were raised to $1,000 before a second opinion clinical dental examination would be required. All dental treatment plans and radiographs are routinely reviewed by the Department after the fee dentist have developed their proposed treatment plans and submitted them to our fee jurisdiction facilities for authorization to provide care. In most instances, this review is sufficient to judge whether the type and extent of the recommend care is reasonable. It is only the more expensive and/or questionable cases that we believe require a hands-on reexamination.

Like most goods and services, inflation has affected the cost of dential care since the legislation was enacted in 1980. For example, a crown and several filings (the need for which is obvious by review of x rays) will now easily exceed the current $500 threshold and require the inconvenience to the veteran and the expense to the VA of a trip to a VAMC to confirm what is already known. Similarly, the cost of dentures automatically exceeds the $500 threshold, but the law requires a hands-on confirmation that the veterans has no teeth . . . a fact again that is quite obvious radiographically.

The fees themselves, tailored on a state-by-state basis, are governed by the Schedules of Maximum Allowances for VA Dental Treatment and would not be altered by elevating the threshold. The Schedules are indexed periodically to the usual and coustomary fees of the dentists in private practice and are not directly revealed to them.

With the safeguards already in place, we do not believe that raising the threshold for reexamination will result in increased costs.

Chairman CRANSTON. John, on February 10, 1989, I wrote you and requested a copy of the December 1988 Quality of Care Task Force recommendations and your evaluation of them. On March 1, you responded that rapid action was expected on the report and that there would be full availability of the document at the completion of its internal review. As of now, 5 months have passed since the task force report was submitted to VA Central Office. I am very concerned about the direction and future of the health-care quality-assurance and risk-management program within VA, particularly in light of the current budget shortfall. John, when will a copy of this report, and your evaluation of and proposed actions on its recommendations be made available?

Dr. GRONVALL. The report has been received and has been acted on, and a copy of the report can be supplied to you immediately, I believe. There is only one complication in that. The report and the followup actions are part of a report that's being prepared to be submitted to the Congress by the Secretary as part of the mandate in Public Law 100-322. So, the set of actions proposed by our task force, and the actions that we've taken on them will be part of that report. But so far as I am aware the specific committee report and the actions we've taken on them can be supplied to you.

Chairman CRANSTON. Section 4107(b)(1) of title 38 links grades and ranges of rates of basic pay for certain title 38 positions to the title 5 general pay schedule. What are the advantages and disadvantages of such a linkage?

Mr. COWLES. The advantages in the past are that it assured consistency throughout at least the Federal Government in setting pay in health-care settings. Although the VA is the predominant employer, there are certain other agencies that employ medical personnel under the title 5 authority. The linkage has provided some consistency in pay practices.

The disadvantages would be that it has, in fact, at times hurt VA's ability to be market sensitive, and to make adjustments in its own schedules. Although we have independent authority in setting special salary rates, to the extent that there's been a linkage, it hasn't provided as great a flexibility as we would have if the linkage was broken.

Chairman CRANSTON. Regarding S. 947, Ron, prior to being able to establish and adjust grades and rates for the covered positions under the competitive pay proposal, facility directors would be required to survey entry-level compensation for corresponding health-care professionals in nondepartment health care facilities.

In order to determine special rates under the current authority, VA facility directors have had to gather salary information from local health-care facilities, is that not correct?

Mr. COWLES. That's absolutely correct, Mr. Chairman.

Chairman CRANSTON. How difficult has it been to obtain such information about entry-level rates?

Mr. COWLES. The experience has really run across the spectrum. There are some communities that very willingly furnish information to us, and we're able to use it, it's reliable. In other cases, unfortunately, the private employers, for whatever reason, may not be fully forthcoming with the information. We may be basing some of our own needs on information that is not either entirely accurate or reliable.

Where we have those kinds of situations, our staff in Washington works with the local staff to try to get better information. The IG, in recent history, has been concerned about that, and have looked at that issue to determine whether VA was in fact setting these rates in a comprehensive manner, and whether the data it was using was reliable. They found some of the same concerns about the reliability of the data.

Chairman CRANSTON. Has there not been a lot of VA experience, already, in doing local surveys of pay rates?

Mr. COWLES. We've had a lot of experience with local facilities trying to get the survey information. The experience, unfortunately, has not always been positive and has not allowed us to set, in some cases, rates which really in fact are competitive.

Chairman CRANSTON. You have special rates at virtually all the medical centers now?

Mr. COWLES. We have 128 authorizations in effect for registered nurses at this point. For some of the other specialty areas like pharmacy, we have special rates, but a goodly number of our medical centers now have such special rates.

Chairman CRANSTON. You probably have them in virtually every one of your medical centers now, correct?

Mr. COWLES. Some type of authorization or another, yes.

Chairman CRANSTON. Vernice and John, are the pay rates of VA nurse and other health-care managers and supervisors comparable to that of their supervisor and manager counterparts in non-VA health-care facilities?

Dr. GRONVALL. I'll answer first, and then Vernice can amplify.

My basic answer is to say, no, that they are not. In fact, the current process for establishing special pay requires that we make a comprehensive finding that we are enough below the existing market on pay, so that it's creating actual recruitment and retention difficulties. In other words, we have to be able to show that we have a problem in order to adopt a special rate. So by the structure of special rates we are always behind. We're not able to achieve and maintain comparability. That's part of the basic approach that we've been taking with our Nurse Pay Task Force to get a restructured basic pay arrangement that would allow us to achieve parity with the local community and maintain it.

Chairman **CRANSTON**. Vernice?

Ms. **FERGUSON**. For comparable work for a nurse in the Veterans' Administration with the private sector, we are not competitive. Our nurses from the direct care provider all the way up to the leader in nursing, take on many activities that in the private sector they would not be required to do.

Chairman **CRANSTON**. Are you referring to supervisors and managers?

Ms. **FERGUSON**. I'm speaking of supervisors, managers, and also reaching down to the direct care provider.

Chairman **CRANSTON**. Ron, does the current title 38 pay system take into account the difference in the scope of responsibilities between employees assigned to entry-level positions and employees holding supervisory or management positions?

Mr. **COWLES**. Yes, it does in many ways. The concept of pay in title 38, at least at the entry level, the level at which a nurse is hired depends upon experience or educational achievement. Professional Standards Boards, as you are aware, will in fact review each application and make recommendations. However, once you are, in fact, working for the Veterans' Administration, and assume leadership positions, and also assume experience in different settings, given different responsibilities, you can then be promoted to various grade levels in the title 38 pay structure. We do have supervisors at a number of those grade levels—we have had nurses that are full-grade nurses, some that are intermediate, we have some that are at the senior grade level—at the same time the fact that they are a manager or a supervisor doesn't provide them, per se, with a higher grade just because of that designation. Normally the grade achievements and the promotions are due to experience in the VA system, and also what we call the proficiency ratings that are done in evaluating the person's ability to succeed as a manager or a supervisor.

Chairman **CRANSTON**. S. 947 would require that, when rates of basic pay are established or adjusted, the rates of pay for newly established grades and steps maintain the same proportional distribution between the rates of steps and grades that currently exists. Also, if a new grade or additional steps within a grade were added by the Chief Medical Director under the new system, the new grade or step would be required to bear the same proportional relationship to other grades or steps as current grades or steps bear to one another.

What rationale exists currently for the proportional differences between the current title 38 grades and for the steps within each title 38 grade?

Ms. **FERGUSON**. Mr. Chairman, one of the joys of the VA system in terms of its pay structure is that one looks at a career. And by having those proportional steps, as well as grades, enables a nurse, even if he or she chooses to remain at the bedside to rise proportionate to their contribution. So that proportionality helps. Otherwise we would be not unlike the private sector in which one offers a very large up front salary to attract the nurse, but as one continues the compression between those who have been aboard and the new hire create that disproportion.

Chairman CRANSTON. Ron, what's the rationale for the proportional relationships that currently exists?

Mr. COWLES. I think some of that is what Vernice has explained here. It is to make sure that, in fact, nurses who have increased responsibility or more experience, or are performing at—and are capable at performing at higher levels and taking on more responsibilities, that there is a differential between what in fact they're making and perhaps the nurse that is working next to them who does not have the same authority or responsibility as a caregiver. And this system is meant to, therefore, recognize the achievement and the ability of a nurse to perform in that health-care setting. It has been an important distinction that we've had.

Chairman CRANSTON. Under S. 947, do you foresee any reason for establishing different proportions between grades and steps within grades, from those that currently exist?

Ms. FERGUSON. Presently the new task force is working on these kinds of proportionality issues as they experiment with different grade structures and that is moving very rapidly. We have the input of personnel service, as one begins to look at it, and we will still see that kind of proportionality protected.

Chairman CRANSTON. Vernice, on page 2 of the NAGE testimony, it's stated that, in VA, there has been a reduction of almost 650 RNs and almost 1,000 LPNs from 1987 to 1989.

Are those accurate figures so far as you know?

Ms. FERGUSON. I'm just looking at that testimony now, and I could not address it as accurate. It does not appear to be, from the data that we get from the paid system.

Dr. GRONVALL. Mr. Chairman, I can provide immediately for you the exact figures. In regard to registered nurses, at the present time, the most recent pay period in April for which we have full information, we had 33,537 FTE of registered nurses on duty. And during that same period we had 25,147 licensed practical nurses, or nursing assistants. To put that in perspective, going back through the past 4 or 5 years, the peak year in the VA health-care system in terms of registered nurses was in 1986. During that year we had 34,109. That's a year long FTE figure, of course, for that year. The peak year in regard to licensed practical nurses was back in 1983, when we had 28,939 FTE that year. So that gives a perspective of the peak period and then our existing actual on-board strength.

Chairman CRANSTON. You're down about 572 RNs from 1986?

Dr. GRONVALL. Yes.

Chairman CRANSTON. What is the cause of the reduction?

Dr. GRONVALL. There is a whole series of factors, of course, involved; pay, relative increase in the demand for nurses in hospitals across the country as patients in hospitals have gotten sicker and demand more intensive care nursing, a decline in the number of nurses being educated by our nursing schools, with, in fact, some nursing schools having been closed.

So the country, as well as the VA, has found itself facing a very serious nursing shortage which is the result of a declining production of new nurses and an increasing demand in the hospital system. That's led to rapid escalation of pay and we have described the problems that the VA has had in being responsive enough to maintain comparable pay and keep adjusting our pay to keep up with our surrounding competition.

Chairman Cranston. Would you take a look at the figures from 1987 to now and give us a written analysis?

Dr. Gronvall. We'd be pleased to supply those in detail for the fiscal years 1987, 1988, and then through the various periods of the current year.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Nursing employment data for the past 3 years is as follows:

	RN	LPN/LVN/NA
1987	33,713.3	26,424.3
1988	33,897.2	26,001.0
1989 [1]	33,626.0	23,666.4

[1] This is an estimate based on cumulative data through the end of March 1989.

Source: Cost Report No. 2, 1987; 839 Report, 1988, 1989.

Since 1987, the number of RNs has decreased by 87.3 FTEE and the number of LPN/LVN/NAs has decreased by 2,757.9 FTEE.

Chairman Cranston. John and Vernice, on page 3 of the NAGE testimony it is stated that: First, it has become standard practice at the Coatesville VAMC to permit personnel on mandatory overtime to bring their children to the nursing station while alternative child-care arrangements are being made; second, in Coatesville, one nursing assistant is left alone on a locked psychiatric ward with patients who are considered dangerous; and third, staffing is so short that RNs are unable to give or receive a patient condition report when they change shifts.

Do you consider those to be safe practices?

Ms. Ferguson. Mr. Chairman, I do not consider that safe practice. I assure you that I will look into this very promptly.

Chairman Cranston. John, do you have any comment?

Dr. Gronvall. No. I have not seen the testimony, and was not aware of that problem.

Chairman Cranston. Please review those situations.

Dr. Gronvall. We will surely review it immediately.

Chairman Cranston. What are the JCAHO standards in regard to these matters?

Ms. Ferguson. JCAHO basically enters an institution and asks you to put forth your plan of care that's consistent with that in the community of caregivers. And then they move among you to see if you're truly doing what you said you were going to do in your plan. So they generically accept broad guidance but make sure that you're towing the line when they walk into your institution by obtaining evidence that you are.

Chairman **Cranston**. If those conditions exist as described, NAGE claims you're not meeting the standards.

Ms. **Ferguson**. They would certainly be concerned about a nursing assistant who is not a professional person being on a locked unit with people who are allegedly dangerous. And that would not be an appropriate standard of care in any community.

Chairman **Cranston**. On page 13 of the ANA's testimony it's stated that, at the North Chicago VAMC, if the chemotherapy nurse is on leave or ill, there is no replacement, therefore, no chemotherapy is administered. Also on page 2 of the written testimony submitted by the American Association for Respiratory Care the statement is made that at the Fresno VAMC, because of lack of staff, patients are not receiving physician-ordered medications and other respiratory care procedures which are of a critical nature. John, would you check into these two situations and let me know if these descriptions are accurate and what is being done to meet those conditions.

Dr. **Gronvall**. Very well.

[Subsequenthy, the Department of Veterans Affairs furnished papers addressing allegations made regarding nursing issues by non-VA witnesses. These papers appear on p. 179.]

Chairman **Cranston**. Vernice, on page 20 of PVA's testimony it is stated that VA has not developed an adequate nurse staffing level which takes into account such things as nurse-patient ratios, staff mix, and the level of care required by patients.

In your opinion are these accurate statements?

Ms. **Ferguson**. Knowing that ours are not standards, but are guidelines, I would consider these statements inaccurate. There's often confusion in the VA system that we have standards for *X* number of nurses, nursing assistants, and LPNs to work with *X* number of patients. Ours are guidelines which offer broad rubrics for individuals to work within and beyond.

I would have to look at their testimony very carefully to comment further.

Chairman **Cranston**. Please do that and report back to us.

Ms. **Ferguson**. I will, and I will report back to you.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The first VA nursing guidelines were implemented in 1982. These guidelines provide an objective basis for determining core nursing staffing (nursing personnel at the "care-giving" level) requirements. The guidelines are a method of classifying patients according to their nursing care requirements related to dependency and amount of direct nursing care provided. The guidelines indicate the hours of nursing care required per patient per day by category of patient. Variations in patient condition, as well as wide differences in knowledge and skill level of nursing personnel performing prescribed activities necessitate the utilization of the guidelines in concert with professional judgement. The vast majority of nursing personnel are currently covered by staffing guidelines. Additional guidelines are in the development phase.

Chairman **Cranston**. Is the current nurse-patient ratio and staff mix adequate to meet the needs of today's veteran patients?

Ms. **Ferguson**. In some settings, yes. In some settings it is woefully lacking.

Chairman **Cranston**. Do you believe that individual VA facilities have allocated adequate ceilings for nursing services?

Ms. **Ferguson**. Sharing with you how varied this is across the system, in some limited settings I would say it matches that which is needed for patient care, and all too many, based on the limited FTE available, the limited number of support people, and the limited number of computers that respond to nursing, the answer is no.

Chairman **Cranston**. Vernice, when budgeted positions are transferred from nursing to other departments because nurses can't be recruited to fill the positions, are the vacancy rates then calculated using the reduced ceiling or are they calculated based on the previous allotment?

Ms. **Ferguson**. The vacancy rate story is a real dilemma, and at the present time I do not look at it as a sensitive indicator of the state of nursing. I was heartened, however, on Monday on meeting with Mr. Haag, who now chairs the new task force, to really find a more definitive way of looking at the nurse vacancies. So vacancy rates are not an extremely sensitive indicator in the VA system at this time.

Dr. **Gronvall**. Mr. Chairman, may I expand.

Chairman **Cranston**. Yes.

Dr. **Gronvall**. If you look at trend data for, let us say, the past 5 years out of an essentially level total number of staff working in our hospital systems, the positions assigned to nursing have gone up significantly and at a rate much more rapid than any other health profession working in our medical centers. That reflects the fact that our medical centers have a great demand for nurses and appreciate the importance of the nursing staff as critical care givers. The problem has been the availability of total budget support for total staff in a hospital.

Chairman **Cranston**. Vernice, I understand that you had the honor of being a member of the Health and Human Services Secretary's Commission on Nursing, and that you took part in hearings which were held across the Nation as well as in developing their interim and final recommendations. Based upon this experience, what do you see as the top five items needing to be addressed so as to enhance VA's recruitment and retention capabilities for nursing personnel?

Ms. **Ferguson**. Thank you.

First, I would share with you I feel that I'm a commissioner for life. It seems as though I've served on every one of them since Florence Nightingale. But having said that, the Department of Health and Human Service put forth some sensitive issues, and in my opinion these would be the top five issues: Number one, both in the public and the private sector, working conditions bear improvement, and a subset under that would mean issues surrounding the scheduling of nurses for duty, the use of computers that respond to nursing time, for our commission found that more than 40 percent of any professional nurse's time is spent on documenting care, and once one brings in computers that respond to nursing you have freed up 60 to 70 percent of that administrative time.

I would share with you that support services are wanting, for many people have found hospital employment unattractive, not only in nursing but in other fields. And also the fact that new health care workers may well come and leave quickly. So working conditions would be a leading concern.

A second one, and I have not set them in priority order, is the pay issue. And this issue comes forward in very bold ways in terms of trying to respond to the marketplace with the demanding work load.

It leads me to the third one, which would be the work load, in both private and public sector. And you've probably seen letters in Ann Landers' column in which nurses, not only in the VA but beyond the VA, have complained that they're frustrated because the demands of care are large.

The fourth one, Senator Cranston, is recognition. And I would like to take this moment to thank you for the very fine personal letters that you sent to the Secretary's Commission on Nursing ceremony on Friday, in which you individually cited Ms. Scott, the registered nurse; Ms. Bethay, the licensed practical nurse from Salem; and the nursing assistant, Mr. Lancaster. This goes a long way in terms of dealing with the recognition of nurses. And these are some of the issues that are large.

And finally, the fifth one becomes education. We don't nearly have enough money in the VA system to be competitive with the private sector to afford either the person who is not a nurse, who wishes to go to school to become a nurse in large numbers, or for nurses to go to school without it coming out of their base pay.

So I would say working conditions, pay, work load, recognition showing value for the nurse, and education are the five determinants of our future, and need to be addressed seriously and continuously.

Chairman Cranston. Thank you, Vernice. You know how strongly I feel about nurses and their role, and the need to have full recognition of their responsibilities, and adequate support. I appreciate your reading my statement. I wish I could have been there.

I'm going to have to leave very briefly to go to an Appropriation's Committee matter, and then I'll be back. And Jon Steinberg will carry on with this panel in my absence. We have just a few more questions for you.

Tony, I do want to thank you for being here and your responsiveness, and your willingness to explore some matters in depth with us. I know that you have other responsibilities and have to leave as soon as your testimony is through, but we'd appreciate it if all the other VHS & RA witnesses, and support personnel remain to listen to the testimony of other witnesses this morning, unless they have absolutely unbreakable commitments elsewhere. I think that such attendance and interest on VA's part is very important to understanding what other people are thinking.

Mr. Principi. Mr. Chairman, I believe it's important as well. Unfortunately, we have a major White House meeting in a few hours regarding Agent Orange. We're going to brief the entire Cabinet. And I certainly need the assistance of Don Ivers and Dr. John Gronvall at our briefing. Becuase we're going to be going over to the White House in a few hours, regretfully, we need to get them back to their work stations as soon as possible. We'll keep a team here to listen and we'll be briefed on the matters discussed.

Chairman Cranston. If the other medical people can remain, I think that would be helpful. Thank you very much.

Dr. **Gronvall.** Mr. Steinberg, may I clarify a response I gave earlier to Chairman Cranston when he asked about sections 223 and 224 having to do with Colorado Nurses decision.

Mr. **Steinberg.** Certainly.

Dr. **Gronvall.** He asked me my comment about—and I don't remember the question exactly, but it was what will be the impact on recruitment if we don't reach accommodation on those two items. My comment was that the VA, as we've deliberated about our position on those two legislative proposals, clearly takes recruitment and retention impact into account. We strongly oppose adoption of those two legislative proposals. I don't mean to minimize the impact of those proposals seen positively and negatively by various individuals and groups on recruitment and retention, but we have taken that into account, I believe, and oppose adoption of those two sections.

I wanted to add that additional clarification. I think earlier I used the term, we don't have a problem. That's an overstatement, obviously.

Mr. **Steinberg.** Thank you very much for that clarification.

Senator Murkowski has indicated that he would like to express his regrets that he was unable to be here to hear the VA testimony this morning. We know, of course, that he will be reviewing the VA submission and the results of this hearing very carefully, and that he has several bills under consideration today. He has a prepared statement that will be printed at the appropriate place in the hearing record. And he is also going to be submitting written questions to you for the record, and we're going to ask that written responses be returned by June 1, if at all possible.

[The prepared statement of Senator Murkowski appears on p. 139.]

Mr. **Steinberg.** Tony, again, we regret that Senator Cranston has to be absent for only a few minutes, and there are just a few more questions we'd like to finish off.

On page 13 of your testimony, you recommend deferring action on restructuring the title 38 pay system, altering overtime, and making changes to the premium pay provisions until the VA nurse task force proposals can be fully developed, reviewed, and submitted through the normal legislative process.

Can you tell us what your timetable is to complete each of these actions, that is full development, review, and legislative submission?

Mr. **Principi.** We'll have the process completed by September, and hopefully get something up to Congress during that period of time.

Mr. **Steinberg.** In other words, by September you would hope that you would have legislative proposals to the Congress?

Mr. **Principi.** That's correct.

Mr. **Steinberg.** Thank you, Tony.

John and Vernice, to date, how do the task force's proposals differ from those proposed in S. 947, if you can enlighten us on that?

Dr. **Gronvall.** I've seen only summary and draft reports and would say that on balance, a majority of the provisions in our view and in these legislative proposals are consistent. But that's not a final position.

Mr. **Steinberg**. Certainly.

Dr. **Gronvall**. However, but I think there's not a wide difference between our view of most of those matters, and the legislation that's now before the committee.

Mr. **Steinberg**. Vernice, do you have any comment?

Ms. **Ferguson**. I would agree with that view. The basic principles have been maintained, rapid readjustment, matching the geographic marketplace, and valuing certain individuals including head nurses.

Mr. **Steinberg**. Thank you.

John and Vernice, and Tony if you wish to comment on this we'd very much like to have your reaction as well, would you agree with the statement that in many VA facilities at this time the nurse vacancy and turnover rates are alarmingly high?

Ms. **Ferguson**. The vacancy rates basically are not alarmingly high, because they are not the sensitive indicators. It is not uncommon when a nursing leader cannot fill the position that it's shifted to another. And I do not look at the vacancy rates as a sensitive indicator. What I do look at are the turnover rates.

Mr. **Steinberg**. I'm sorry, we said turnover rates and vacancy rates.

Ms. **Ferguson**. Right. I wanted to share with you I consider the vacancy rate a far less sensitive indicator based on how we allocate positions. If we were the Army, Navy, or Air Force with fixed billets, and you didn't take them away, you could look at it this way. But ours are floating.

On the other hand turnover rates are still deceiving until you ask the larger question, how many times during this year did this one position turn over? It is one thing to say you have all of your positions filled, but it's another to say that you filled the ICU nurse position five times. And I think that is the larger question that needs to be addressed. And we spent a lot of time on that in the Secretary's (HHS) Commission as well.

Mr. **Steinberg**. Are there data as to that?

Ms. **Ferguson**. It is not that sensitive, because we are not highly computerized at every level of the medical center to show how often the one position turned over. But to me that is the by far more critical indicator, and when I walk on a unit with nurses to ask these kinds of questions, that's the kind of response that I get and look for.

Mr. **Steinberg**. And do you get a response as to that sort of individual position turnover that suggests that at a number of medical centers there's a serious problem?

Ms. **Ferguson**. Yes, in terms of position turnover in the urban American highly affiliated institutions.

Dr. **Gronvall**. You asked me to comment, Mr. Steinberg. I don't know whether the word alarmingly is the right word. But we have a very serious problem, particularly in, as Vernice says, large cities where the combination of competition from many surrounding hospitals has outstripped our ability to pay appropriate pay, and where there are rapidly escalating, extremely difficult patient care demands from patients with AIDS, for example, very difficult kinds of medical and surgical problems. That combination has produced a very serious problem in delivering care in those parts of the country. So I surely would not want to minimize the negative impact on our capacity and ability to deliver care as a result of the nursing shortage.

Mr. STEINBERG. Thank you.

Tony?

Mr. PRINCIPI. I might just add, Jon, that I have had the opportunity to visit a few of our facilities and recognize the shortage of nurses. I don't believe it's alarming. And to put it in the proper context, it seems to me that based upon a few visits I've made to private community hospitals, if it's alarming, it's just as alarming in those hospitals as it is in the VA.

And as we talk about these benefit improvements, pay and education, and I think individual and collectively they're terribly important and we have to move ahead, I think we have to focus on the underlying fundamental problem, and that is the nursing shortage in this country, the role of nurses in the future in America and how we can stimulate more young men and women to make nursing their profession of choice. Pay is important and the other material benefits are important, but until society recognizes the important role of nurses in our society, we're going to continue to have the problem and be pitted against the private sector, and there are going to be band-aid approaches in my view.

Mr. STEINBERG. Thank you.

Senator Murkowski, Senator Cranston had to testify at the Appropriations Committee. He left about 5 minutes ago. We expect him back very, very shortly. He asked me to complete a few questions that he had intended to ask before he left. I will, of course, yield to you at this point if you wish, or I will complete the questions that he asked me to ask, whatever you prefer.

Senator MURKOWSKI. Thank you very much, Jon.

This is a rare occasion, Mr. Principi. And I can't say that I'm prepared for it either. [Laughter.]

I gather you've got a little Washington mildew this morning.

Mr. PRINCIPI. Yes, sir, I sure do. It's good to see you, Senator.

Senator MURKOWSKI. I don't want to overlook the contribution of the other members of the panel. It's just that Mr. Principi and I have had a relationship—he worked for me for several years.

Mr. PRINCIPI. I must admit that I did find it more comfortable sitting at that end of the table. [Laughter.]

Senator MURKOWSKI. Knowing of your sensitivity to the issue of nursing, which perhaps emulates from the occasional input from your wife, if you recall some time ago we passed a program that would provide a recruitment and retention bonus for nurses who would be willing to commit for an extended period of time. I don't know if it has been discussed this morning. I think it was either your idea or your wife's—but you took the credit for it. [Laughter.]

I'm curious to know if that's been successful, has it been given a fair shot? Is it an adequate inducement?

Mr. PRINCIPI. I certainly will defer to Dr. Gronvall and Vernice to discuss at some length. We have not implemented the bonus program to date. We have a VA nurse pay task force that has been looking at various incentives to recruit and retain our skilled nurses. And we've asked them to take a look at the bonus program that was offered by you, sir, last Congress, and to see whether it would, in fact, assist us in solving some of our critical shortages in those areas in a cost-effective way by targeting the dollars where the problems are without creating undue morale problems as well. And we hope to have the report of the task force in a short time, and hopefully will implement the bonus program.

Senator **Murkowski**. Where would the money come from to pay the bonus?

Mr. **Principi**. It would come out of our medical care account, our personnel care dollars.

Senator **Murkowski**. You mentioned a concern over maintaining a balance for those that wouldn't get this kind of bonus. Is that a problem of morale?

Mr. **Principi**. I think any time you implement a bonus program you do tend to create the haves and the have-nots. It traditionally has been a problem. Even at the Department of Defense where we have shortages of aviators and nuclear submariners, we target dollars for them because we just don't have the luxury of providing it across the board. So you do tend to create some morale problems. But I think it has to be looked at in the context of the critical shortage of nurses in the VA, and our society, and the fact that we have to compete. Nursing is a good way of focusing bonus dollars where the shortages are. And in an ideal world, perhaps you would not want to use bonuses, but I think perhaps we have to look at them in the context of the overall shortage.

John or Vernice?

Dr. **Gronvall**. Nothing additional.

Ms. **Ferguson**. Nothing additional.

Senator **Murkowski**. We've always had a concern over the adequacy and the ability of VA to attract competent nursing professionals, which is so important. It's my understanding that this is not a situation peculiar to VA, but it's true throughout the health-care industry, and has been for a long time, I gather. The desire of a person to go into nursing seems to have diminished. The educational requirements relative to the demands and the pay scale are often cited as reasons for the interest in nursing.

Can, for the record, anybody cite statistics that would lead us to believe it's any worse in VA's system than it is outside VA?

Dr. **Gronvall**. Senator Murkowski, a comment on that, and then I think we should follow up with a written response to that specific question. But for the past several years I've been a member of the Board of Trustees of the American Hospital Association, and I can tell you that at every meeting of that group, which is virtually all directors of community hospitals across the entire country, a large part of the discussion is about the negative impact of the national nursing shortage. So, Mr. Principi was making that comment on that fact just before you came in, that he's had also the personal experience of seeing the negative impact of that on community hospitals.

Coming up with a precise, comparative statistics about the relative impact in the VA and in the non-VA hospitals across the country is difficult. There are some yardsticks and some measures, and I think we should supply that as a followup comment for the record. But it clearly is a national problem. The VA is a part of that national problem. We have some unique issues in the VA, but it is fundamentally a national problem.

Senator **Murkowski**. Well, you gentlemen and lady obviously are professionals in the area. And rather than revert to a lot of research for the record, I'd prefer to have your best judgments. I guess the question before us is, is VA any worse or any better than the private sector in the area of attracting adequate nurses? And are private sector nurses any better or worse than the quality of nurses in VA?

Dr. **Gronvall**. I think Ms. Ferguson is in the best position to comment on that.

Senator **Murkowski**. Well, then we'll let her comment on it.

Dr. **Gronvall**. She just recently served on Secretary Bowen's National Nursing Commission. So, she has a very well-informed perspective.

Ms. **Ferguson**. I would share with you that the comments that you've heard this morning are very accurate. The issues surrounding nursing are universal and one has to stay on one's toes to be as dynamic and as competitive.

I have just returned in the last week from New York, for the Commonwealth Fund through Mary Mahoney, its president—has just finished a major study done by Eli Ginsberg, Mark Robinsey, economist from Harvard, as well as two nurses. And this is the largest data base to date of nurses in six major cities. They took an econometric model showing two cities in which the economy is declining, two in which it's stable, and two in which it's growing. And across the board the story sounds not unlike our VA story in terms of too few young people between the ages of 18 to 24, the average age group who have chosen nursing as a career, are choosing nursing, and the fact that the average age group of a nurse has increased, and hospital employment is not as attractive as before.

So we have new phenomena now for years to come to deal with the older person who may not take kindly to rotating three tours and having a major work load.

In addition, just for information, the Robert Wood Johnson Foundation, and the Pugh Foundation have also entered the array and they have put forth major programmatic money in order to assist in restructuring the hospital environment. Those awards will be given this year. Some VA medical centers did compete. Those that are not to be awarded will be looked at very critically by us in the VA and right now two of us are putting together packages, hoping to pilot it. So, in sum, not only has the Federal Government taken a major role in terms of the nursing shortage, but so have major foundations, the Commonwealth Fund, Robert Wood Johnson, and Pugh. And in addition, there is active discussion with Dr. J. Sanford at the Uniformed Services University to determine whether it is feasible to have a nursing school there.

Senator **Murkowski**. Do you see any drift of where nurses are moving professionally as they graduate from nursing school. I recognize a private hospital perhaps can be more innovative just because of the fact that it has flexibility that a larger system does not. But the larger system—such as VA—can offer some long-term benefits and I assume it's pretty hard to beat the Federal Government retirement from some of the mail I get from my constituents who are not receiving it. I'm just curious, where are the new nurses going?

Ms. **Ferguson**. New nurses tend to work for the first 1 to 3 years in medical centers, and many of them choose critical care nursing. Some of them, then leave the critical care environment, as a hospital employee, and become contract nurses selling their services back at sometimes twice that cost because they had more control over their lives or schedules.

I learned of a new phenomena while out in San Francisco in March, many nurses in that community are earning quite well by working the Baylor Plan 3 days a week, hence there are fewer of them available over a 7-day period. So that has come back to haunt us, in terms of I can accrue enough money working 3 days a week in order to live well, and therefore, 4 days are no longer afforded to the institution to have their services.

So the hospital is attractive, people, when they do not have compelling schedules that please them, or other perks, choose to sell their services back to you at their own demand.

Senator **Murkowski**. If you were going to do a spread sheet, Tony knows what I'm referring to in practice, but it gives me a greater ability to glance at something and understand it. The benefits and the attractiveness of VA soliciting nurses vis-a-vis the non-VA system, are there noticeable differences?

Ms. **Ferguson**. Let me answer in another way based on the Secretary's (HHS) Commission on Nursing. This was the first commission that was asked to give special attention to DOD, VA, and the Public Health Service. On balance, we, meaning the Feds, are career oriented services which are extremely attractive over time. The issue becomes the new nurse who gets a high entry salary, may not be interested in becoming vested in the retirement system, may not be interested in health insurance. That's the first rub. But over a lifetime, and especially in a community where the economy is down, the Feds can't be beat. And this came out loud and clearly in the work of the Commission on nursing.

And in the private sector it is not uncommon for those of us who have worked there to know that you'll get your largest salary in the first 3 years, and after that you're expected to be gone. The VA system honors a person's career and offers the opportunity for salary, as well as career progression.

Senator **Murkowski**. Just two other questions, and then I'll yield to Senator Cranston.

I'm curious—I gather that VA has more nurses in their system today than they ever have? Is that correct?

Dr. **Gronvall**. No. At the present time we do not have more nurses working than we've had in the past. Our peak year for registered nurses was in 1986. Our peak year for licensed practical nurses was in 1983. So we're down slightly now from those peak years.

Senator **Murkowski**. What number are you down to currently?

Dr. **Gronvall**. Well, we're down, at the present time, in registered nurses to about 33,500, and practical nurses to 25,150.

Senator **Murkowski**. So that's down what, 2 percent, 10 percent?

Dr. **Gronvall**. If you add those two together from the previous peak years, I think we're down about 4 percent.

Senator MURKOWSKI. Is the reason that you can't get nurses or you don't have the money?

Mr. PRINCIPI. I think it's a combination of factors.

First, we've closed some beds. We're somewhat of a smaller system and obviously we need less nurses. Recruitment is a little bit of a problem, based upon geographic region, and——

Senator MURKOWSKI. Well, what I don't understand is that we haven't had a war in a long time so we don't have the volume that we did during or immediately after a war—such as procedures associated with spinal injury, burns, skin grafts, and so forth. This is a different type of medical procedure, I assume, as the veteran ages. We're getting more and more calls to address long-term care, because we have a hospital system that wasn't designed, necessarily, for long-term care. The nursing requirements, I assume, are different in the two different scenarios. As the age of the veteran increases, the nursing care decreases in the sense of types. Don't you have less surgery associated with issues like spinal operations, corrective burn surgery and things like that? Now it's more related to just the aging of the veteran and his medical needs associated with aging. Is that correct?

Ms. FERGUSON. We're not unlike the private sector in terms of the fact that due to technological advances, and being able to do more, we're running more intensive care units than we've ever run. In fact, in this country the first intensive care units came on line in the sixties, and the VA has not been unlike the private sector. Patients are sicker, and as they get older, with multiple body systems compromised, the amount of time and the talent of a nurse is by far more phenomenal than in yesteryear. If you walk through any of our acute medical center units, one phenomena will strike you, the larger number of people who are lying in those beds with many pipes in every orifice, I recall those days when we had the walking wounded, whereby they could actually assist you in care. That is no longer true.

Senator MURKOWSKI. Thank you.

Dr. GRONVALL. Actually, Senator Murkowski, if I could just add to that. If you take the total population of patients we serve and it is the same in the private sector hospitals, with aging the number and intensity of acute medical and surgical problems increases, and, in addition, there are expanding long-term care needs.

Even if you take surgical procedures, it's not until you get into the decade of the late seventies or eighties, in terms of age, that the amount of surgery begins to fall off as a function of age. So with increasing aging, the demand placed on our hospitals increases both for acute medical care, medicine and surgery, intensive care, as well as long-term care.

Senator MURKOWSKI. This is my last question, I promise.

VA this year opposed my legislation to authorize VA to provide health-related services—such as homemaker, transportation, assistance in bathing, dressing and so forth—for certain veterans.

We have a case in Alaska, and this has been written, so that I'd be sure to get it correct. But an elderly veteran is in need of and receives community nursing home care for a service-connected disability. VA is paying for his care and will indefinitely do so because he needs this care for a service-connected disability. This care is costing VA $8,000 a month. Now this veteran's family wants him at home. They're willing to take the responsibility of caring for him. His family will need help in order to do that, but they're willing to do that. His family has indicated that they need only help in dressing, bathing and transportation within the house. They can't understand why VA will pay $8,000 a month to keep him institutionalized, and not pay minor costs that would permit them to care for him at home.

Does this make sense to you? Why shouldn't VA do this? What should I tell this veteran's family who's saying, hey, we're willing to do it, give us an opportunity to do it.

Mr. PRINCIPI. No, it doesn't. I'm aware of some of those cases, as you know, Senator, and I certainly agree with you that homemaker services, grooming, chores, bathing, are very important and are efficient and cost-effective. The question becomes is that an appropriate function for the VA medical care system? Or is that really more a function for the community services, working with our social workers and our volunteer services, to coordinate the delivery of those homemaker services to enable the veteran to stay at home.

We're not sure it's a logical extension of our medical care system per se, that we need to take very limited financial dollars and move in that direction. But we certainly see the need for those kinds of services, and we're working on programs whereby we coordinate our volunteer services and our social workers coordinate with the community, which has the infrastructure to provide those services and make sure that we're doing so, and keeping veterans at home.

Senator MURKOWSKI. We're not asking for VA to provide services directly, just pay for them.

Mr. PRINCIPI. The problem is we don't get more money to pay for it. So we have to take it out——

Senator MURKOWSKI. VA's paying $8,000 right now. I'm glad to see you're on the other side of the table. [Laughter.]

Well, I would appreciate an answer. I'm going to go back to Alaska tomorrow night, and I'm going to look these folks up, and say talk to the head cheese, he's going to give you an answer.

Mr. PRINCIPI. We'll certainly provide one to you, sir.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The provision of "health-related" services, normally defined as homemaker, chore, home-delivered meals, home health and transportation services, would greatly expand the mission of the Department. While we have supported the provision of health services in noninstitutional settings (i.e., Hospital Based Home Care and Adult Day Health Care), we have relied on community agencies to provide health-related services through an extensive referral network.

The use of "health-related" services as a substitute for nursing home care has been studied extensively. The most comprehensive examination of these services was HHS's National Long-Term Care Channeling Demonstration, completed in 1986. The Channeling project and the other studies have consistently found that the services improved the quality of life and were extremely popular with clients but did not substitute for nursing home care and remain an add-on cost.

In the case you cited, in Alaska, we would encourage the family to contact VA Social Work Service and the local Area Agency on Aging to determine what kind of home care treatment program can be developed.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Chairman **Cranston**. John and Vernice, I want to ask you this question. Is it your testimony this morning that the VA problems with recruiting and retaining nurses is no worse in the VA than in the community at large?

Give us a very brief answer, yes, or no, if you can.

Dr. **Gronvall**. Well, I don't think I can answer that precisely. Based on my experience in talking to people who manage hospitals elsewhere in the country, I don't detect a difference in the perception of the extent of the problem. But that's not a sophisticated answer, and I don't believe we have available the kind of data that would allow a precise answer to that question. It surely is a national problem impacting negatively all hospitals.

Chairman **Cranston**. Vernice, do you feel it's no worse in the VA than elsewhere?

Ms. **Ferguson**. I'm in no position to really quantify it at this moment. Based on the hearings across the country, based on the work of the Commonwealth Fund, it's a generic national problem, and I see commonalities across the whole country. But I've not been able—I had not thought of quantifying it in that way, because I don't have that hard data for that specificity.

Chairman **Cranston**. Doesn't a lower staffing ratio in the VA make it harder for nurses? Isn't it tougher for them?

Ms. **Ferguson**. The lower staffing ratio certainly does for work load issues are large.

Chairman **Cranston**. Doesn't that create a retention problem?

Ms. **Ferguson**. Yes, it does.

Chairman **Cranston**. That retention problem would not be the same elsewhere?

Ms. **Ferguson**. But if you read the reports of the private sector one of the things that's catching up with them, and for those of us who were a part of the national commission hearings, Senator Cranston, if you would have closed your eyes, you would have thought you were hearing the VA described. Work loads are increasing across this country for nurses. Nurses want more lifestyle changes and better schedules, and that is why many of them are selling their services back to us as contract nurses, or fee-basis nurses.

Dr. **Gronvall**. Just one other dimension to that. In the country last year something over 100 hospitals closed as a result of financial duress. So it is surely not the case that all hospitals, other than the VA in the country, are basking in largess, and are able to pay whatever they want to hire people.

Chairman **Cranston**. But obviously the nurse staffing ratio is more adverse in the VA than elsewhere.

Dr. **Gronvall**. That's correct.

While you were out, Mr. Chairman, we were asked whether our nursing problem was alarming, and we discussed that word a little bit, but both Vernice and I, and Mr. Principi repeated how serious the nurse shortage impact is on our hospitals, particularly in large cities. So, we're not in any way trying to minimize the fact that it is a very serious problem.

Chairman **Cranston**. On page 20 of your prepared testimony, you state that you cannot support raising the overall cap on special salary rates except in the instance of intermediate grade registered nurses where you could support a more restrictive measure.

Vernice, it is my understanding that the maximum special rate is being paid to junior grade registered nurses in 15 VA medical centers and to associate grade registered nurses in four VAMCs. Is that an accurate statement?

Ms. FERGUSON. Yes, it is.

Chairman CRANSTON. Do you believe that your ability to recruit and retain nurses at those facilities I just described as being affected by the cap is impeded by your ability to offer higher salaries?

Ms. FERGUSON. It is.

Chairman CRANSTON. It is stated on page 28 of the VA testimony that VA would support the appointment of graduates of Affiliated Allied Clinical Health-Care Education programs to competitive civil service positions without regard to competitive civil service procedures if minimum requirements were set for applicants to be hired.

What sort of minimum requirements are you referring to?

Mr. COWLES. Sir, those would be requirements that the VA sets for a number of occupations, VA-specific qualification requirements which indicate that a certain level of education, experience, and demonstrated performance have been met. It is, if you will, an opportunity to review and act on a case-by-case basis that individuals have acquired a minimum level of experience and education to be able to successfully give care.

Chairman CRANSTON. Nothing in our proposed legislation would prevent you from doing that.

Mr. COWLES. That is correct.

Chairman CRANSTON. Don Ivers, would you please provide a draft of the legislative language that you suggest and submit it to us?

Mr. IVERS. Yes, Senator.

Chairman CRANSTON. On page 23 of the testimony, when discussing dependent care assistance programs, it's stated that an employee participating in a cafeteria plan may not use the tax credit for child-care expenses. Has VA established any cafeteria plans whereby employees may choose the benefits they wish to have?

Mr. PRINCIPI. It's under discussion in our task force.

Chairman CRANSTON. There are none at this time?

Mr. PRINCIPI. No.

Chairman CRANSTON. Senator Jeffords raised a question about the House action and medical-care money versus construction money. We've tried to ascertain the facts and Jon Steinberg will briefly report on that matter.

Mr. STEINBERG. Tony and John, I thought you might find this interesting, so I wanted to do it before you left. As we understand it from the House Appropriations Subcommittee, the thrust of the Post article is that the $340 million, all of which is for medical care, and none of which is for construction, is not offset by cuts elsewhere. The article then goes on to report that the House Appropriations Committee added five specific projects worth $64.6 million, three of which were not requested by the Department, with the inference that perhaps there should have been an offset by depriving those projects of money to offset part of the $340 million.

So what we want to clarify is there is no construction money in the $340 million Urgent Medical Care Supplemental pending in the House, and, of course, you would be quick to point out that even if an offset was sought out of construction money for medical care money, it would serve very little, if any, purpose since the outlay rate on construction money is in the single digit percent, I think 5 percent, and the outlay rate for medical care money is approximately 86 percent.

But, for the record, and I hope that that will be shared with Senator Jeffords, we have clarified that there is absolutely no construction money in the House Supplemental Appropriations bill that is pending at this time.

Dr. **Gronvall**. And Mr. Principi had commented on that that in the supplemental there are some equipment funds that will be used to purchase equipment for projects that need to be activated, but there are no construction starts in our request.

Mr. **Steinberg**. Yes, we now have that fully amplified from the House side. So, thank you all very much.

Chairman **Cranston**. Thank you very much. That completes our questions of you, and we appreciate your help on this.

Mr. **Principi**. Thank you.

Dr. **Gronvall**. Thank you.

Ms. **Ferguson**. Thank you.

Chairman **Cranston**. Our next panel is composed of representatives of nursing organizations. Could Margaret Stafford, representing the American Nurses' Association, and Claudette Morrissey, representing the Nurses Organization of the VA, please come forward.

You're with us again, Claudette. It's a pleasure to see you again. Margaret, would you please lead off with a 5-minute summary of your testimony. I want to remind you of our 5-minute rule.

Ms. **Stafford**. I'll try.

Chairman **Cranston**. Thank you.

STATEMENT OF MARGARET C. STAFFORD, CLINICAL NURSE SPECIALIST, VA MEDICAL CENTER, HINES, IL, ON BEHALF OF THE AMERICAN NURSES' ASSOCIATION

Ms. **Stafford**. Good morning, Senator Cranston, and other interested parties. I am Margaret Joan Stafford, a Clinical Nurse Specialist at Edward Hines, Jr. VA Hospital. I have been there for 17 years in that capacity. Prior to that I was a coordinator of a program that sponsored continuing education and was funded through the Department of Health Education and Welfare. I also worked in a variety of roles at Cook County Hospital in Chicago, IL., so I come with much experience in taking care of critically ill patients, and patients within our VA community.

I am here today as a member of the American Nurses' Association, which has represented VA nurses in collective bargaining since 1967, through their State Nurses' Associations. But I would like to stress that in that capacity I am here on behalf of our veteran patients, and the people who care for those veteran patients.

It is interesting to note, people at Hines were aware of the fact that I was coming today, and I received several calls from VA service representatives, other nurses and physicians, all very eager for me to try to get across their specific vested interests. But all of their vested interests related to the care that they wish our VA patients to receive.

ANA has reviewed S. 13 and supports that bill. Our written statement addresses all of the bills before you, however, I will focus on the issues related to the VA's competitiveness as stated in S. 947, as well as title 38 collective bargaining procedures.

We feel strongly that nursing's ability to engage in effective collective bargaining must be maintained, as it impacts favorably on VA health-care personnel retention and recruitment. The National Labor Relation Board's decision to recognize all RN bargaining units in the private sector indicates that the VA will have to compete with comparable contracts as well as salaries and benefits.

ANA believes the title 38 employees are afforded the same labor-management rights as other Government employees and we wholeheartedly endorse, section 223. The Court of Appeals ruling on collective bargaining will have an adverse impact on the VA's ability to attract health-care professionals. The discretionary application of title 5 personnel procedures is viewed as depriving nurses of their rights and only exacerbates the recruitment and retention difficulties.

INA local unit nurses from Hines and Westside VA met with Secretary Derwinski to discuss critical issues related to the deterioration of our patient care, the nursing shortage, and collective bargaining. We urged Secretary Derwinski to implement the recommendations of the Federal Commission on Nursing, and to set up a task force to report to him. My informal communication system tells me that he has been very responsive to our requests, and we feel comfortable that he will not do anything to further demoralize the nurses in the VA system.

We all know that VA hospitals in the past have been in the forefront of nurses' salaries, benefits, education, and professional development. However, the private sector has responded much faster to the market demands. Currently, the budget crunch makes one wonder if there even is a budget. Many nurses are actually identifying ways and means to recruit independently from the budget, using their own time and moneys to do so.

Reductions in funding also have resulted in a significant reduction in nurse mix in several VA hospitals. Illinois and California VA hospitals reported freezes in the employment of RNs. Imagine a freeze in a situation like this where everybody has identified the nursing shortage nationally.

Several hospitals have reduced their RN ceilings. Nurses are being rotated to units without sufficient orientation. I think this is a very critical situation. Managers are instructed to increase non-RN staff to make up for RN reductions, while high LPN and LVN vacancies and turnovers, and reductions in their ceilings also exist. A decrease in RNs means that the VA will be using more numbers of lower skilled employees. As this continues, veterans are deprived of essential life preserving care and treatment. Nursing staff and support personnel, salaries, and general funding for basic equipment as well as for high technology, and safety measures within the environment must be increased. Three thousand beds are closed due to nursing shortages. Computer assistance for nursing is almost negligible. And yet that has been cited as one way to relieve the nursing crunch. We have an excellent computer program in process, but not adequate funds to really help it move forward. Nurses who need to have continuing education programs are unable to attend the programs because of staff shortages. These conditions certainly inhibit recruitment as well as retention.

We support the intent of S. 947, but have some concerns regarding the administration of the program as it is written. Surveys of basic pay to determine pay adjustments must reflect specific criteria, be consistent and——

Chairman CRANSTON. Finish the sentence or the paragraph.

Ms. STAFFORD. Instead of finishing that sentence, I'll say one more thing to summarize. It is an alarming situation.

Thank you. I'll respond to any questions or elaborate as indicated.

[The prepared statement of the American Nurses' Association appears on p. 182.]

Chairman CRANSTON. Thank you very much.

Claudette?

STATEMENT OF CLAUDETTE MORRISSEY, PRESIDENT, NURSES ORGANIZATION OF THE VA

Ms. MORRISSEY. That bell is very interesting today.

Mr. Chairman, I wish to thank you for inviting NOVA here today, and for having heard us when we appeared before you in the past.

This legislation before us is a demonstration of your understanding of our past statements, and your commitments to the future of the veterans health care. The legislation particularly addresses the area of nurse compensation and NOVA is pleased to bring the prospectives of working VA nurses to this hearing and will comment on the appropriate sections of S. 947.

NOVA strongly supports the purpose of title 1, pay matter, section 101, which is to ensure that VA health-care facilities are competitive on the basis of pay and other employee benefits in the recruitment and retention of qualified personnel for such positions. NOVA appreciates the intention of the committee that the salary scale for nurses be competitive with, but not exceed the wage rate paid in a given community. However, NOVA recommends that the VA nurse entry level of GS-6 be the base below which salaries would not be decreased, since according to the American Nurses' Association, the current VA entry-level salary of $17,500 is well below the lowest average salary of $18,400 paid in March of 1987 in the Western North-Central part of the United States.

NOVA is particularly pleased to hear that it is your intent that the determination of competitive pay by the facility director would be made with the input of the individual chief nurse. NOVA suggests having the annual salary surveys take place in June of each year, rather than in December. Since the January cost-of-living allowances have become a great morale factor for VA nurses, we felt it would be better not to interfere with them in any way.

NOVA was gratified to hear that the issue of the overtime pay cap would be addressed in this legislation. For it is one that our members have brought to our attention frequently since it seems to defy their beliefs in common sense and fair play. The overtime rate is currently limited to one and a half times the usual hourly rate of pay until the maximum of $20 per hour is reached. Thus, a nurse who is a Full Grade Step 5, receives 1.5 times the hourly rate. The percentage is gradually reduced for each step thereafter until Senior Grade Step 7, where the nurse would in fact be making less at the overtime rate than they do at their regular rate.

NOVA also supports section 103 which provides for an additional 6 percent pay differential for head nurses; section 104 which calls for a waiver of reduction in retired or retainer pay for registered nurses; and section 105 which will provide for implementation of special salary rates when necessary.

NOVA is pleased to see the recognition of nurses for specialty recertification with a lump sum payment of 1 percent upon recertification. And NOVA commends you for the creative provisions introduced under title 2. The dependent health-care provision is particularly exciting, because many VA nurses have responsibilities for minor children, dependent spouses, elderly parents or others. And benefits in these areas will make VA medical centers a more attractive place to work.

NOVA additionally appreciates the committee's recommendations for sections 301 and 302 under title 3 of this bill.

In summary, Mr. Chairman, NOVA commends the provisions in this bill, and believes it is a positive move toward making VA more attractive and competitive with the private sector in the recruitment and retention of nurses. NOVA thanks the committee's continual commitment in addressing the nursing shortage, its affect on patient care, and nursing's vital role in the VA mission to provide quality health care. Recruitment and retention of registered nurses in the VA system is imperative, for not only do RNs provide health-care services of demonstrative quality more cost effectively than any other health care given, registered nurses are the frontline health professionals who can properly deliver and coordinate the health-care and recovery process of veteran patients.

Therefore, NOVA asks the support of all the members of this committee to approve the approaches reflected in S. 947 and to assure that this legislation will be accompanied to an appropriation request that will make it possible for directors of medical centers to carry out the recommendations.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Morrissey appears on p. 200.]

Chairman **Cranston**. Thank you very much. I appreciate both of your testimonies with your general support for the legislation that I've introduced.

Claudette, I appreciate your constructive and supportive comments in regard to those provisions addressing the recruitment and retention of nurses and other health-care professionals. I also note your comment on the extension of the respite care program. I believe nurses have a great deal of knowledge about general health-care issues, and I'm pleased that you're offering us the benefit of your insights and encourage you to keep up this practice.

You state on page 2, Claudette, of your testimony that you support the purpose of section 101 of S. 947, which is to ensure that VA health-care facilities are competitive on the basis of pay and other employee benefits and the recruitment and retention of qualified personnel for such positions. However, you also recommend that this competitive pay provision be in addition to, rather than instead of, annual COLAs. If the annual December 1 survey under S. 947 were required to presuppose that a COLA would be provided on January 1, in accordance with Government-wide pay actions, so VA would have to affirmatively decide against the need for a COLA in order to stop the COLA, would that help, in your opinion?

Ms. **Morrissey**. I think it would. As I stated, the COLAs, for some reason, become a very emotional, and a very morale factor kind of thing. When nurses look around and see that other people get the COLAs and they didn't, regardless of the percentage, I think it really bothers them. But, yes, I think your suggestion would be fine.

Chairman **Cranston**. Good.

Margaret, when discussing the competitive pay provision in S. 947, you state on page 14 of your testimony that "surveys must reflect specific criteria, and be based on reliable methodologies to assure consistency throughout the VA system." Should these criteria and methodologies be spelled out in title 38, or should they be set in regulations promulgated by VA?

Ms. **Stafford**. I think what's essential is that the regulations be set. We are concerned that when we do our surveys, those agencies being surveyed to maintain their edge on recruitment might not give us all of the facts. And I think that this has to be tightened up, the deadline should be set as to when the VA should be responsive to this need.

My concern is that many bills have been passed, and they are excellent in nature, but by the time they are funded, it's too little, too late. I believe, for instance, the bonus bill and other monetary incentives are excellent, but we have not realized any of them significantly up to this point. We are losing nurses.

Chairman **Cranston**. Thank you very much. I appreciate both of your testimony greatly.

The third panel we'll now hear from this morning is made up of representatives from unions, which represent certain VA employees. I welcome Arte Pierce of the American Federation of Government Employees; Ed Murphy of the National Association of Government Employees; and Marie Winslow of the National Federation of Federal Employees to the witness table.

Again, I want to remind you of the 5-minute rule. I'm going to have to go to a Foreign Relations Committee meeting, and it's a pretty tight schedule. Arte, would you please begin.

STATEMENT OF ARTE J. PIERCE, PRESIDENT, NATIONAL VETERANS' ADMINISTRATION COUNCIL, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. **Pierce**. Thank you, Mr. Chairman. I'm Arte Pierce of the American Federation of Government Employees, and I'm president of the National VA Council which represents more than 100,000 VA employees. And we are in all 50 States, and we have somewhere in the area of 172 locals.

I want to make it clear to the committee that although my primary role is that of a representative of the employees, that those employees who work for the VA are as much concerned about the care of the veterans of this Nation as they are about their personal benefits. On many occasions I get stress calls from people in the field when hospital wards are being closed, and the initial reaction that I get from those calls are, what are we going to do for those veterans. The wards are closed and we're not going to be in the position to render service.

I want to agree with Senator Rockefeller when he indicated that we indeed do have a crisis in the area of nursing care. It was interesting to note that Ms. Ferguson, when outlining some of the factors that we need to look at to improve the nursing care situation, one of the first ones that she identified was working conditions. In light of that I have some problem as to why the VA is taking a negative position in connection with section 223 of the bill that would allow the Secretary to enter into collective bargaining phase the same as he's done under the provision of title 5.

This section 223 would give us the ammunition that we need to override the Colorado Nurses decision. And let me say that the court decision dealing with Colorado has had a negative impact throughout the country. In many, many instances we are getting local directors who are refusing to talk with the labor representatives at their particular station because they feel that the presence of the Colorado Nurses decision is a road block, and they're saying specifically in too many instances we not only won't talk with you, we don't have to talk with you. So this necessitates my having to talk with the people at the Central Office and trying to get this straightened out. And believe me, we have this as a reply from many directors, even in those areas where we have negotiated agreements dealing with the title 38 people.

Section 224 would provide for a grievance procedure involving disciplinary actions, and it's obvious from the context and the language that the exercising of that grievance procedure would in no way, hinder the authority of the Secretary to carry out his duties as mandated in the title 38.

Section 221 provides for a study of the VA security system. And let me tell you, throughout this country the security forces at the VA have a very, very low morale. There are instances where on some shifts there are only three police officers on duty charged with the responsibility of trying to protect the whole hospital. Two working police officers and one supervisor.

Mr. Chairman, there are people who get up in the morning and leave home, and part of their dress code includes carrying a weapon just like putting on their shoes and socks. And they leave home with the intent of doing bodily harm to anybody who tries to deter whatever they want to do. And some of those persons visit our VA facilities.

S. 947 relates to the critical problem of recruitment and retention of nursing care people. The VA has been able to provide good nursing care and has been able to maintain a reasonable retention primarily because of the common bond that exists between our employees and our veteran clientele. We know there's a national shortage in all categories of nurses and we need to do something to attract those nurses who are still out there to come into the VA.

We've expressed great concern over proposed legislation which would authorize special pay and bonuses to certain groups of employees. This is only going to exacerbate an already serious situation and we propose that an across-the-board upward adjustment in the DVA pay schedule be provided to all of the people involved in nursing care.

I want to thank you for allowing me to give you this brief testimony. We are really prepared to go much longer, but I think if I could get the 10 or 15 minutes that I want, I'd have all of you crying, when I gave you our hard luck story. So, thank you and we appreciate appearing before you this morning.

[The prepared statement of Mr. Pierce appears on p. 211.]

Chairman CRANSTON. Thank you very much for your very helpful testimony.

Mr. Murphy?

STATEMENT OF ED MURPHY, LEGISLATIVE COUNSEL, NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES

Mr. MURPHY. Good morning, Mr. Chairman.

On behalf of our membership I'd like to express our thanks for this opportunity to come in this morning and testify on S. 13 and S. 947.

First of all, our union strongly supports provisions in S. 13 which addresses the collective bargaining rights problem that was created by the Court of Appeals last year in the Colorado Nurses decision. As a result of that decision, professionals in the VA are at the mercy of management with respect to collective bargaining. Management has full discretion to participate or not participate in collective bargaining, and if they participate under what terms and under what circumstances. Needless to say, effective collective bargaining cannot take place where the parties have such unequal powers and rights.

In addition to being unfair to the affected workers, the absence of meaningful collective bargaining rights is an impediment to recruitment and retention. Collective bargaining is perhaps the most commonly used and effective means to provide workers with input into workplace decisions. Nurses are particularly concerned with this option. The absence of this right in the VA provides an additional recruitment and retention problem.

S. 13, as you are well aware, would just maintain the pre-Colorado Nurses status quo. And as such, is an eminently fair proposition.

Second, this legislation provides needed changes to section 4110 disciplinary/grievance review. Under current law title 38 employees are limited to an in-house review which is cumbersome, time consuming and at times of questionable competence. S. 13 makes needed changes to improve the due process protections accorded to employees facing disciplinary review, and expands the role of the negotiated grievance process in addressing these issues. We regard this provision as a much needed reform which will provide fundamental rights long withheld from professional employees.

With respect to S. 947 pending before the committee today, this legislation is also a creative attempt to address recruitment and retention problems by providing the local hospital administrator great flexibility to set pay in accordance with local compensation. It also addresses certain inequities in the current special rate authority, and makes a number of other meaningful changes to employee benefits and to personnel requirements.

The NAGE applauds the Chair for this effort to improve pay and working conditions of VA professional employees, and to address the severe recruitment and retention problems. The vast majority of professional employees in the VA are currently under special rate authority. There are many inequities in this special pay system which this bill addresses. For instance, many hospital administrators use special rate authority to hire employees at above the minimum step of the grade, and then fail to increase the salaries of those experienced employees and staff who are performing the same duties. This created an inequitable and counterproductive situation where senior employees were paid less than new hire employees with substantially less experience. Special rates applied in this manner exacerbated existing morale and retention problems. The legislation under consideration today would correct this situation by mandating that when special pay is accorded to new hires then all workers in the position will have their salaries increased, irrespective of their step in the grade. This, in our view, is an important correction to a major flaw in the bill.

The legislation also takes needed steps to accelerate the process of granting special pay increases. Far too frequently the process for gaining approval of special increases is cumbersome and time consuming.

We also support provisions in the bill to provide RNs with time and one-half for overtime. This benefit is commonly provided in the private sector and its absence in the VA is an unnecessary impediment.

The major change to the pay system for title 38 professionals under consideration today would be to grant broad discretion to the hospital administrator to establish pay in accordance with a local survey. The NAGE has some reservations, in all frankness, about establishing a locality based pay system. We believe that the basic concept of Federal pay system in comparability with the private sector is a sound one, but that the concept has been destroyed by the discretion accorded to the President to cap pay.

In our view pay caps are chiefly responsible for the widespread use of the special pay rate in the VA, and for the recruitment and retention problems. We believe the solution to the pay problems Government-wide and in the VA is to restrict the ability of the administration to cap pay.

We also have some concerns about the mechanics in establishing the pay rate under the bill. There are a few standards established for the pay survey and great discretion granted to the local VA hospitals. There are a lot of technical questions involved in doing such a survey, and we question whether the VA currently has the capability to do such surveys on a broad and regular scale.

Finally, we note that there is no provision allowing for union involvement in this pay setting process. We think this is important in light of the absence of clear cut standards. And, of course, we want to have a say in establishing pay rates.

Mr. Chairman, in conclusion, we would like to thank you once again for this opportunity to appear. We pledge our full cooperation to working with you to advance this legislation.

[The prepared statement of Mr. Murphy appears on p. 230.]

Chairman CRANSTON. Thank you very, very much.

Ms. Winslow?

STATEMENT OF MARIE WINSLOW, LEGISLATIVE LIAISON, NATIONAL FEDERATION OF FEDERAL EMPLOYEES

Ms. WINSLOW. Thank you, Mr. Chairman.

I would like to say that NFFE commends the committee for its efforts to solve the growing recruitment and retention problem among health-care workers in the VA. And we agree with you, Mr. Chairman, that we must do all we can to enable the VA to attract the best and the brightest health-care personnel in the system.

S. 947 addresses this challenge by establishing competitive pay rates, which would be based on surveys with competing employers, generally in the same geographic area. NFFE has some experience with geographic compensation programs in the Federal Wage System, which sets pay for blue collar employees. The Federal Wage System, as you may know, has 143 wage areas which are surveyed completely once every 2 years. S. 947 calls for almost 200 surveys to be conducted annually. In the FWS, the members of the lead union in the wage area participate in the survey process, and are able to help validate job matches, but even so there are problems that arise every year. Some of these problems include employers who are unwilling to participate in the survey, even when they have a good job match; a lower morale in those areas which are not entitled to a pay increase, even though they have very high productivity; and resentment when no raise is granted, even though these employees face increasing costs that are set nationally, such as their health insurance rates.

Unfortunately the potential exists for all these problems to manifest themselves in the proposed health-care pay program as well.

In terms of the survey proposal, as well as the other aspects of S. 947, there is one key element missing and that's the opportunity for employee participation through union representation at all levels of the process. NFFE would urge that any legislation permit the unions to bargain with VA on this program to ensure its success. If the competitive pay rates are neither created equally, nor maintained equally, the system would fail in its stated goal of improving recruitment and retention.

NFFE also has concerns that the VA medical directors will not have sufficient expertise to conduct valid surveys. Our statement includes many questions we have about how employees would fare under particular circumstances. And while we understand the committee's reluctance to include a lot of detail on how this survey should be run, we are not as confident as members of the committee are that directors would never be motivated to delay realistic compensation rates.

I'd now like to move on to S. 13 which would restore collective bargaining rights for title 38 employees in the Department of Medicine and Surgery. As you are aware, the Colorado Nurses decision was a departure from the precedent of the last 20 years where bargaining between labor organizations and the Veterans' Administration over proposals from safety and health to career and training were routine. We know of no situation in which the VA's mission of providing medical services was ever hampered in any way by bargaining with management over conditions of employment. And frankly, we were appalled that the VA came here today opposing collective bargaining for these employees.

We feel that the provision of S. 13 which provides title 38 employees with collective bargaining should be a cornerstone of any legislation to improve the program of health care for our Nation's veterans. The VA statement pledged the Secretary's intention to continue collective bargaining obligations, but without passage of S. 13, there are no obligations.

As you noted, Mr. Chairman, our statement included references to conditions at Northport VA and I would like to point out that with me is NFFE National Vice President, Georgiana-Kachura, a nurse at that hospital who would be happy to answer any specific questions you might have on that.

We have one concern about S. 13 and that is the portion of section 224 which requires the use of arbitrators who also qualify as health-care professionals in any disciplinary actions involving a question of clinical competence. We think this is a very noble goal, but we are unsure whether there is a significant number of these individuals available, and we are aware that the Federal Mediation and Conciliation Service has no means to identify these individuals. If we cannot establish that sufficient numbers of these qualified people are available, then we would counsel that the portion of legislation be altered, so as simply not to delay the process any further.

That concludes my statement.

[The prepared statement of Ms. Winslow appears on p. 245.]

Chairman Cranston. Thank you very much. Your statements have been very, very helpful. I'll be submitting written questions to you. I have two short items to cover now, and ask you to please respond very, very briefly.

First, would each of you very briefly describe your views on the current morale of VA employees in light of refusals by VA management at some medical centers to bargain regarding working conditions? If you could just reply in a few words, what it's like.

Arte, we'll start with you.

Mr. Pierce. I'd say the morale is very low. Employees are saying that if we don't have collective bargaining rights where are you going to go. We have people in the professional area with degrees, who do not have rights equal to the title 5 people and I had one comparison the other day; here I am a nurse with several degrees, I don't have the same rights as the groundskeeper.

Chairman Cranston. Ed?

Mr. **Murphy**. Mr. Chairman, I would say it's just an additional injury to the workers. They view this as a means to address workplace decisions, a means to have a voice in it. It is taken away from them as an effective tool, and I think it's damaging.

Chairman **Cranston**. Marie?

Ms. **Winslow**. Mr. Chairman, there is a problem in morale, and I noted that when members of the VA were answering the question, is it any worse in the VA than it is in the private sector, I would just say that it may not be a lot worse in the VA than it is in some private sector hospitals, but that's certainly not much of a goal, Mr. Chairman. We should want to be better.

Chairman **Cranston**. Thank you very much. And thanks for being succinct and direct and helpful.

If there continues to be no resolution between the various interests involved in this issue, that is, if the Colorado Nurses decision remains as the last word, what do you believe will be the impact on VA employees who are members of your organizations over the next few years?

Mr. **Pierce**. I think we're going to have a problem retaining membership in our organizations, and I think we're going to have a problem retaining professional people in the VA. They can leave and go outside and they can beat the VA on pay, they can beat the VA on schedules, and they can also get collective bargaining rights. So what they're saying, is why should I stay here when I can do better by going across the street?

Chairman **Cranston**. Do you both agree with that?

Mr. **Murphy**. Yes, Mr. Chairman.

Mr. **Pierce**. Yes, Mr. Chairman.

Chairman **Cranston**. Earlier I asked Tony Principi to look into the allegations regarding management's refusal to bargain at Northport, NY, Togas, ME, and Fargo, ND. As you heard, he graciously agreed to look at those situations. Would you please provide directly to him the details at those stations, and any others of which you may be aware in a timely fashion, and send copies of that information to us?

Ms. **Winslow**. Yes, Mr. Chairman.

Chairman **Cranston**. Thank you very, very much.

Our final panel consists of Richard Christian, Deputy Director, National Veterans and Rehab Commission, and Mr. Samuel Walsh, Assistant Director, National Legislative Commission, The American Legion; Dave Gorman, Assistant National Legislative Director, Disabled American Veterans; Gordon Mansfield, Associate Director for Government Relations, Paralyzed Veterans of America; James Magill, Director, National Legislative Service, Veterans of Foreign Wars; and Tom Sherwood, Director of Health Care Policy Planning, Vietnam Veterans of America.

Thank you all for your presence. Mr. Christian, would you start?

I want to remind you again of the 5-minute rule. If you can do it in 3 minutes, I will be grateful, because I have to be somewhere at 11:30.

STATEMENT OF RICHARD S. CHRISTIAN, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY SAMUEL J. WALSH, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION

Mr. CHRISTIAN. Yes, sir.

We appreciate the opportunity to offer The American Legion's views on several proposals relating to veterans health-care services scheduled for consideration at today's hearing. I will summarize the issues of major concern to The American Legion, which are contained in our written statement.

Mr. Chairman, The American Legion strongly supports the proposed extension of the State Home Program to 1992. It is an important link in the Federal/State efforts to meet the needs of our aging veteran population. The American Legion is also supportive of the intent to expand the Secretary of Veterans Affairs authority to enter into sharing agreements with medical facilities but requires assurances that any such agreements, the VA does not lose any of the control over its responsibilities for providing medical care to veterans.

The American Legion is generally supportive of the establishment of a task force to ensure the continued availability of programs to provide a wide variety of medical-care services and assistive equipment to eligible disabled veterans.

With regard to S. 573, we are totally opposed to this provision. The means test and third-party reimbursement have changed the nature of the VA health-care program. We are opposed to totally smoke-free in the medical centers. They should designate smoking areas for our veterans.

The American Legion fully supports the provision to provide respite care to 1991. The authorization to provide premium pay for certain nursing assistants should be favorably considered. To authorize retired military nurses to be employed by the VA without loss or reduction of retired pay will help improve the severe shortage of nurses. Treatment of dental conditions on an outpatient basis, rather than an inpatient basis, would be a far more cost-effective means of preparing a veteran for hospitalization.

Mr. Chairman, we appreciate your concern and efforts toward improving the competitive standing of VA health-care personnel. The provisions of S. 947 appear to improve substantially the medical center director's capability to establish competitive wages and benefits for health-care personnel.

Mr. Chairman, that concludes our summary.

[The prepared statement of Mr. Christian and Mr. Walsh appears on p. 254.]

Chairman CRANSTON. Thank you very, very much.

Mr. Gorman?

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman.

As our written testimony will indicate, we're in general agreement with virtually all of the legislative issues on the hearing agenda today. And what I'd like to do is take the remainder of my time and talk about four specific issues.

The first being, section 225 of S. 13, that proposes the creation of a task force to be established by the Secretary to recommend policies and legislation for the elimination of inconsistencies among various provisions of law relating to veterans' eligibility to certain health-care benefits.

Mr. Chairman, we do not necessarily disagree with your assessment that the various sections of title 38 pertaining to veterans' eligibility for medical and assistive devices lack consistency and a clear meaning. We wish to relate our concern, however, regarding the composition of the task force in the absence of any non-DVA representation. If it is felt that a task force is indeed warranted, then we would urge amending language be inserted directing that at least two representatives from veteran service organizations be appointed to such a task force. We believe it imperative that VSOs be involved in the front end and be active participants in any dialogue that occurs relating to this issue, which is obviously of utmost concern and importance to the most severely disabled service-connected veteran.

I would like to briefly address S. 573, Mr. Chairman, that the DAV adamantly opposes. In our view this measure sends a clear signal to service-connected disabled veterans that yet another earned benefit and entitlement is being stripped from them. We view this proposal as simply an attempt to require veterans to pay for the privilege extended by Congress and a grateful Nation of utilizing earned VA benefits. And, in fact, entitlements under current law.

Mr. Chairman, the provisions of the measure, if enacted into law, would be bad for veterans and bad for the VA. We reiterate our opposition to this measure.

I would like to discuss S. 574 and specifically section 7, which proposes to add a new section regarding noninstitutional alternatives to nursing home care. The DAV supports this concept, Mr. Chairman. We have long advocated that providing necessary medical and certain nonmedical services to veterans to avoid hospitalization is a desirable approach both from a cost-effective standpoint, and more importantly for the over well-being of the veteran.

Finally, our comments would be directed to S. 947 introduced by yourself, Mr. Chairman, which represents, in our view, an extremely comprehensive and far-reaching measure designed to provide the VA necessary authority and flexibility to recruit and retain qualified health-care personnel. You are to be commended for your continued recognition, Mr. Chairman, and commitment to ensure that an adequate cadre of qualified health-care professionals are employed within the VA health-care system, in order to provide quality medical services to this Nation's disabled veterans.

As we look back over the years, it becomes readily apparent to us that many of the enhancements in the area of employment of health-care professionals have enjoyed both your advocacy and your untiring support. For that you have the gratitude of the DAV.

It is, therefore, a pleasure to extend the full support of the organization to the general provisions of S. 947.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Gorman appears on p. 268.]

Chairman CRANSTON. Thank you very much, and I thank you for your appreciation of my efforts.

Mr. Mansfield?

STATEMENT OF GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Mr. MANSFIELD. Thank you, Mr. Chairman.

The first thing I'd like to say is that PVA would like to thank you and the members of this committee for your continuing efforts to get additional and required funding for the VA health-care system. I'd also like to thank you and Senator Murkowski, and the other members for introducing this legislation. And I'd also like to say to the representatives from the nurses, and the unions, that PVA understands that the people out there at the medical center level are making this system work under great stress, and we thank you.

With that, I would like to submit my statement for the record, and be prepared to answer any question you may have.

[The prepared statement of Mr. Mansfield appears on p. 282.]

Chairman CRANSTON. Thank you very, very much, and that's very helpful in my time problem. I appreciate it very much.

Mr. Magill.

STATEMENT OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. MAGILL. Thank you for the opportunity to present the views of the Veterans of Foreign Wars with respect to the various health-care legislative proposals before us today. Inasmuch as you have our prepared statement, and we also have heard all of the provisions of the various bills, at your request, I also will be very brief in my remarks.

With respect to S. 13, the VFW supports sections 211, 213, 214, 215, 222, and 225. We would recommend that section 211 be expanded to include the adoption of a child, and that section 225 be amended to include the VSOs in the task force.

The VFW has no objection to advancement of S. 165. With respect to S. 573, we can see no benefit to veterans with this bill, and therefore, we do not support the enactment of this legislation. The next bill, S. 574, also contains several sections. We support sections 7 and 8. With respect to section 4, we prefer the language of S. 13 in that it requires the VA to implement the program. We do not support section 5, and while we certainly support section 6, which extends respite care, we again would like to see this program made permanent. Finally, Mr. Chairman, the VFW supports S. 748 and S. 947. Thank you.

[The prepared statement of Mr. Magill appears on p. 316.]

Chairman CRANSTON. Thank you very, very much.

Tom.

STATEMENT OF THOMAS A. SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA

Mr. **Sherwood**. Mr. Chairman and members of the committee, we appreciate this opportunity to present our views at this time which excludes legislation on mental health which will be addressed in the June 14, 1989 hearings before the committee.

We certainly do support S. 13. With regards to S. 165, construct a medical research center for the Department of Veterans Affairs and the Medical University of South Carolina in Charleston, we do express some concern. In terms of the veteran patient is there a demonstrated need for this project? How will veterans be specifically served by this joint venture for which the taxpayer will have to pay in a time of severe budget constraints and DVA budget shortfalls? What will be the name of this research center? In addition to the $12 million up front cost the DVA will have to put up, how about the recurrent costs relative to staff, and supplies, and equipment that will have to be taken into account thereafter. Have the necessary feasibility studies been done, at least relative to the arrangements to ownership, management, joint operations, and specific responsibilities. What impact will be had on the project if for fiscal year 1991 or beyond the VA finds it cannot, in fact, fund this venture?

We recognize the value of such projects relative to local economies as well as their value to the overall economy of this country, but we need to be assured that veteran needs come first and that the DVA is involved in ventures they can pay for, while at the same time not without meaningful and significant control of the venture in the interest of the veteran for whom this DVA exists.

With regard to S. 573, to provide for third-party reimbursement to the U.S. Government, we have some concern. VVA needs to be assured that the veteran will not be inconvenienced regarding the provision of health-care services if DVA and third-party payers are involved in attempting to resolve administrative problems that they may face or that may surface regarding the administrative arrangements of implementing this joint venture. VVA recommends that all veterans, regardless of service connection, who are insured by third-party payers be eligible regarding this legislative proposal, providing those dollars go directly to the medical centers.

We support S. 899 to authorize the Secretary of Veterans Affairs to establish and conduct a 5-year program involving leave sharing for medical emergencies of employees of the Department. We support S. 900, this having to do with furnishing respite care to chronically ill veterans.

We certainly support S. 947, a bill to improve the conditions of employment for employees of the Veterans Health Service, and Research Administration. We also support S. 947.

I would take time to remind this committee of the Management Efficiency pilot program which was established. As you may recall, five DVA medical centers in this program are being administered with limited DVACO control as a part of a time limited project to determine the value associated with decentralizing medical centers.

The medical centers involved were the Boise, ID, Indianapolis, IN, Long Beach, CA, and also Minneapolis, MN and Richmond, VA. Also, there's such a project with the Department of Veterans Benefits—the other half of DVB. This project has not been tracked, as far as we can tell. For DM&S this project has not been followed up as far as we can tell. There was a 2-year limitation on the project for which we should have had feedback, and that has not occurred—certainly not at the Central Office level. I would strongly suggest that we pick up on this project to continue to see if, in fact, we can manage these medical centers independently of the usual rules and regulations and the heavy hand of DVA.

Finally, Mr. Chairman, none of the legislation under consideration at today's hearing addresses the issue of extending the DVA's authority to provide health care to Agent Orange and radiation exposed victims. The existing authority which places these veterans in category A status, as we understand it, is currently scheduled to expire at the conclusion of the fiscal year. We strongly urge that this committee extend this authority without delay.

Once again, thank you very much for giving me the opportunity to speak.

[The prepared statement of Mr. Sherwood appears on p. 322.]

Chairman CRANSTON. Thank you very much. I thank each of you for your testimony, for your general supportive stance on the legislation that I've introduced and we are considering. I thank you also for being here throughout the morning, for being so brief and taking into account my needs. I have to get to Foreign Relations almost instantly.

I do have some questions, but I'll submit them in writing to you and ask for a timely response by June 1. Sam, I know you were here to introduce Dick, and forgive me for not giving you that opportunity.

I want to say to you, Dick, that I believe this is your first appearance before us on behalf of the American Legion. We remember very well your excellent work at DOD in researching Agent Orange spraying records. Congratulations on your new position.

I have one comment. The DAV, PVA, and VFW recommended we put VSO representation on the section 225 task force to review eligibility for various assistive programs. We will be considering that with great care and very seriously.

I thank all who have been here, all who have attended, all who have helped us as so many of you have. And we now stand adjourned. Thank you very much.

[Whereupon, at 11:26 a.m., the committee adjourned, to reconvene at the call of the Chair.]

APPENDIX

101ST CONGRESS
1ST SESSION

S. 13

To amend title 38, United States Code, to increase the rates of disability compensation and dependency and indemnity compensation for veterans and survivors, to increase the allowances paid to disabled veterans pursuing rehabilitation programs and to the dependents and survivors of certain disabled veterans pursuing programs of education, and to improve various programs of benefits and health-care services for veterans; and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 25 (legislative day, JANUARY 3), 1989

Mr. CRANSTON (for himself, Mr. MATSUNAGA, Mr. DECONCINI, and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to increase the rates of disability compensation and dependency and indemnity compensation for veterans and survivors, to increase the allowances paid to disabled veterans pursuing rehabilitation programs and to the dependents and survivors of certain disabled veterans pursuing programs of education, and to improve various programs of benefits and health-care services for veterans; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Benefits and Health Care Act of 1989".

SEC. 2. REFERENCE TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE II—HEALTH CARE

PART B—OTHER HEALTH-CARE PROGRAMS

SEC. 211. SERVICES TO OVERCOME SERVICE-CONNECTED DISABILITIES AFFECTING PROCREATION.

Clause (A) of section 601(6) is amended to read as follows:

> "(A)(i) surgical services, (ii) services to achieve pregnancy in a veteran or a veteran's spouse when such services are necessary to overcome a service-connected disability impairing the veteran's procreative ability, (iii) dental services and appliances as described in sections 610 and 612 of this title, (iv) optometric and podiatric services, (v) (in the case of a person otherwise receiving care or services under this chapter) preventive health-care services as defined in section 662 of this title, (vi) (except under the conditions described in section 612(f)(1)(A)(i) of this title) wheel-

chairs, artificial limbs, trusses and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Secretary determines to be reasonable and necessary, and (vii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and".

SEC. 213. STATE HOME CONSTRUCTION GRANTS.

Section 5033(a) is amended in the first sentence by striking out "September 30, 1989" and inserting in lieu thereof "September 30, 1992".

SEC. 214. PILOT PROGRAM FOR FURNISHING ASSISTIVE ANIMALS TO CERTAIN VETERANS.

(a) REQUIREMENT FOR PILOT PROGRAM.—During fiscal years 1990, 1991, 1992, and 1993, the Secretary of Veterans Affairs shall conduct a pilot program under which the Secretary shall—

(1) furnish (A) to not more than 20 quadriplegic veterans who have service-connected disabilities rated 50 percent or more, monkeys that are specially trained to assist in the performance of daily living tasks for quadriplegic individuals, and (B) to not more than 10 such veterans, dogs that are so trained; and

(2) facilitate the furnishing of monkeys that are so trained to not more than 20 other quadriplegic veterans.

(b) SELECTION OF VETERAN-PARTICIPANTS.—(1) In determining whether to furnish a monkey or dog referred to in subsection (a) to a veteran, or to facilitate the furnishing of such a monkey to a veteran, under the pilot program, the Secretary shall (A) consider the extent to which the veteran needs and can benefit from the assistance of the monkey or dog, and (B) provide a preference for veterans who have service-connected quadriplegia.

(2) The Secretary shall approve a veteran for participation in the pilot program only upon the Secretary's determination that the veteran is well-suited for—

(A) carrying out the responsibilities involved in the care of the monkey or dog; and

(B) effectively using the monkey or dog for assistance in performing the veteran's daily living tasks.

(c) ADMINISTRATIVE MATTERS.—(1) The Secretary is authorized to enter into contracts for the furnishing of assistive monkeys and dogs under subsection (a)(1). Under such contracts the Secretary may make advance payments for the furnishing of the monkeys or dogs before receipt of the monkeys or dogs and may either reimburse the provider of such monkeys and dogs for the costs of training the monkeys or dogs or, subject to such terms and conditions as the Secretary determines necessary to protect the interests of the Government, make advance payments for such costs before the costs are incurred.

(2) Ownership of an animal furnished to a veteran under the pilot program shall be determined in accordance with a contract between the provider of such animal and the veteran.

(d) EVALUATION AND REPORT.—(1) The Secretary shall evaluate the conduct of the pilot program, the nature and extent of the benefit to veterans furnished animals under the program (including any benefits related to employment), the costs and cost-effectiveness of furnishing animals to quadriplegic veterans, and the effects of such program on the recruitment and retention of paid primary caregivers for veterans receiving such animals and on the morale of unpaid primary caregivers for such veterans.

(2) Not later than February 1, 1993, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the experience under the pilot program. The report shall contain—

(A) the results of the evaluation carried out under paragraph (1), including descriptions of the procedures and criteria used to select veterans to receive monkeys or dogs, the nature and extent of the benefit that the veterans received from the assistance of such monkeys or dogs, and the amounts and types of costs incurred by the Department of Veterans Affairs in the conduct of the program;

(B) the Secretary's views on the relationship between the furnishing of a monkey or dog to a veteran and the payment to a veteran of (i) an aid and attendance allowance under section 314(r) of title 38, United States Code, or (ii) an annual rate of pension under section 521 of such title based on the veteran's need of regular aid and attendance; and

(C) any recommendations that the Secretary considers appropriate regarding whether the pilot program should be continued or whether the authority to furnish assistive monkeys and dogs to quadriplegic veterans should be made permanent.

(e) DEFINITIONS.—For the purposes of this section, the terms "veteran" and "service-connected" have the meanings given those terms in paragraphs (2) and (16), respectively, of section 101 of title 38, United States Code.

SEC. 215. PILOT PROGRAM FOR PROVIDING SIGNAL DOGS TO CERTAIN VETERANS.

(a) SIGNAL DOGS PILOT PROGRAM.—(1) Except as provided in paragraph (2), during fiscal years 1990, 1991, 1992, and 1993, the Secretary of Veterans Affairs shall conduct a pilot program under which the Secretary shall furnish signal dogs (as defined in subsection (e)(2)) to not more than 20 veterans who have service-connected hearing impairments and are in need of the assistance of such dogs.

(2) The Secretary is not required to conduct a pilot program under this section if the Secretary determines that the provision of such dogs to such veterans by the Department of Veterans Affairs is authorized under chapter 17 of title 38, United States Code.

(b) SELECTION OF VETERAN-PARTICIPANTS.—In making a determination whether to furnish a signal dog to a veteran under the pilot program, the Secretary shall consider the extent to which the veteran needs and can benefit from the assistance of the signal dog. The Secretary shall approve a veteran for participation in the pilot program only upon the Secretary's determination that the veteran is well-suited for carrying out the responsibilities involved in the care and effective use of the signal dog.

(c) OWNERSHIP OF SIGNAL DOGS FURNISHED TO VETERANS.—Ownership of a signal dog furnished to a veteran under the pilot program shall be determined in accordance with a contract between the provider of such dog and the veteran.

(d) EVALUATION AND REPORT.—The Secretary shall—

(1) evaluate the conduct of any pilot program carried out under this section, the nature and extent of the benefit that the veterans received from the assistance of the signal dogs furnished under the program (including any benefits related to employment), and the costs and cost-effectiveness of furnishing such dogs to veterans who have hearing impairments; and

(2) include in the report required by section 114(d)(2)—

(A) the results of the evaluation carried out under clause (1), including descriptions of the procedures and criteria used to select veterans to receive signal dogs, the nature and extent of the benefit that the veterans received from the assistance of such dogs, and the amounts and types of costs incurred by the Department of Veterans Affairs in the conduct of the program; and

(B) any recommendations that the Secretary considers appropriate regarding whether the pilot program should be continued or whether the authority to furnish signal dogs to hearing-impaired veterans in need of the assistance of such dogs should be made permanent.

(e) DEFINITIONS.—In this section:

(1) The terms "veteran" and "service-connected" have the meanings given those terms in paragraphs (2) and (16), respectively, of section 101 of title 38, United States Code.

(2) The term "signal dog" means a dog specially trained to provide hearing assistance to deaf persons.

PART C—HEALTH-CARE ADMINISTRATION

SEC. 222. SHARING OF SPECIALIZED MEDICAL RESOURCES.

(a) EXPANSION OF PURPOSE.—Section 5051 is amended by striking out "hospitals" both places it appears in the first sentence and inserting in lieu thereof "health-care facilities".

(b) REVISION OF AUTHORITY TO SHARE SPECIALIZED MEDICAL RESOURCES.—Section 5053 is amended—

(1) in subsection (a)—

(A) by striking out "hospitals" the first place it appears and all that follows through "community" and inserting in lieu thereof "health-care facilities and other health-care facilities (including organ banks, blood banks, or similar institutions), research centers, or medical schools"; and

(B) by striking out the last sentence; and

(2) in subsection (b)—

(A) in the first sentence, by striking out "charge" and all that follows and inserting in lieu thereof "methodology that provides appropriate flexibility to the heads of the facilities concerned to establish an appropriate reimbursement rate after taking into account local conditions and needs and the actual costs to the providing facility of the resource involved."; and

(B) in the second sentence, by inserting before the period at the end "and to funds that have been allotted to the facility that furnished the resource involved".

SEC. 223. COVERAGE OF VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION PERSONNEL BY FEDERAL EMPLOYEES' COLLECTIVE BARGAINING PROCEDURES.

Section 4108 is amended—

(1) by striking out "Administrator" each place it appears and inserting in lieu thereof "Secretary";

(2) by striking out "Veterans' Administration" each place it appears and inserting in lieu thereof "Department of Veterans Affairs";

(3) by striking out "Department of Medicine and Surgery" each place it appears and inserting in lieu thereof "Veterans Health Services and Research Administration";

(4) in subsection (a), by inserting "except as provided in subsection (e) of this section," after "Notwithstanding any law, Executive order, or regulation,";

(5) in subsection (c)(2), by striking out "non-Veterans' Administration" and inserting in lieu thereof "non-Department of Veterans Affairs";

(6) in subsection (d), by inserting "except as provided in subsection (e) of this section," after "Notwithstanding any other provision of law,"; and

(7) by adding at the end the following new subsection:

"(e) The provisions of chapter 71 of title 5 shall apply to the exercise of the Secretary's authority under this section except with respect to—

"(1) the prohibitions set out in paragraphs (1) through (6) of subsection (a) of this section; and

"(2) the matters covered by section 4110 of this title.".

SEC. 224. DISCIPLINARY ACTIONS AND GRIEVANCES.

Section 4110 is amended—

(1) by striking out subsection (a) and inserting in lieu thereof the following:

"(a)(1) The Chief Medical Director, under regulations prescribed by the Secretary, shall from time to time appoint disciplinary boards to determine, upon notice and fair hearing, the charges in any disciplinary action brought against a person employed in a position listed in paragraph (1) of section 4104 of this title (hereafter in this section referred to as the 'respondent') on the basis of the performance or conduct of such person during employment with the Department of Veterans Affairs.

"(2) A disciplinary board appointed in the case of any respondent shall consist of not less than three nor more than five employees of the Veterans Health Services and Research Administration who are senior in grade to the respondent.

The majority of the members of such board shall be employed in the same category of position as the respondent.

"(3) The Chief Medical Director may delegate the performance of the function of appointing a disciplinary board to an employee of the Veterans Health Services and Research Administration who is not involved in deciding whether to file charges to be determined by the board and who is not subordinate to any official involved in making such decision.";

(2) in subsection (b), by striking out "Administrator" and inserting in lieu thereof "Secretary";

(3) in subsection (d)—

(A) in the first sentence, by striking out "suitable" and all that follows and inserting in lieu thereof "that the proposed disciplinary action be sustained or modified within limitations prescribed by the Secretary.";

(B) in the second, third, and fourth sentences, by striking out "Administrator" each place it appears and inserting in lieu thereof "Secretary";

(4) in subsection (e), by striking out "Administrator" each place it appears and inserting in lieu thereof "Secretary"; and

(5) by adding at the end the following:

"(f)(1) A disciplinary board is not required in the case of a disciplinary action if the proposed action is suspension for 14 days or less, reassignment without a reduction in basic pay, reduction in rank without a reduction in basic pay, reprimand, or admonishment.

"(2) An employee against whom a disciplinary action described in paragraph (1) of this subsection is proposed to be taken shall be entitled to—

"(A) an advance written notice stating the specific reasons for the proposed action;

"(B) a reasonable time to answer orally and in writing and to furnish affidavits and other documentary evidence in support of the answer;

"(C) representation by an attorney or other spokesperson; and

"(D) a written decision and the specific reasons for the decision at the earliest practicable date.

"(3) Disciplinary actions described in paragraph (1) of this subsection shall be subject to review under either the provisions of section 4120A of this title (in the case of employees appointed under authority of this title who are members of a unit determined appropriate under section 7112 of title 5) or an agency review procedure to be established by the Secretary (in the case of such employees who are not members of such a unit). Any such agency review procedure established by the Secretary shall include—

"(A) an informal review of the decision on the disciplinary action by an official of a higher level than the official who made the decision;

"(B) a prompt decision by such higher level official and a right to formal review by an impartial examiner within the Department of Veterans Affairs;

"(C) a prompt report of the findings and recommendations by the impartial examiner; and

"(D) a prompt review of the examiner's findings and recommendations, together with any comments by the employee and the Department on such findings and recommendations, by an official of a higher level than the official who conducted the review pursuant to clause (A) of this paragraph.".

(b) GRIEVANCES.—(1) Subchapter I of chapter 73 is amended by adding at the end the following new section:

"§ 4120A. Grievances and certain disciplinary reviews

"(a)(1) The Secretary shall authorize review of Department of Veterans Affairs actions on the following matters under procedures established by collective bargaining in accordance with the provisions of chapter 71 of title 5:

"(A) Grievances of employees appointed under authority of this title who are members of a unit determined appropriate under section 7112 of title 5.

"(B) Subject to paragraph (2) of this subsection, disciplinary actions described in subsection 4110(f)(1) of this title involving such employees.

"(2) In the case of a review of a disciplinary action involving any question of clinical competence, as determined by either party, any person selected to serve as an arbitrator in such case under procedures established as provided in paragraph (1) of this subsection must be qualified as an arbitrator and must also be (A) qualified as a physician, dentist, or nurse, or (B) otherwise qualified, by specialized experience or training or both, in examining and adjudicating health-care issues.

"(b) For the purpose of resolving grievances of supervisors and employees appointed under authority of this chapter who are not members of a unit determined appropriate under section 7112 of title 5, the Secretary shall authorize review of action of the Department on such grievances pursuant to a Department review procedure established by the Secretary under section 4110(f)(3) of this title.".

(2) The table of sections at the beginning of chapter 73 is amended by adding at the end of subchapter I the following new item:

"4120A. Grievances and certain disciplinary reviews.".

SEC. 225. DEVELOPMENT OF RECOMMENDED LEGISLATION FOR THE ELIMINATION OF INCONSISTENCIES IN CERTAIN VETERANS BENEFITS LAWS.

(a) REQUIREMENT TO ESTABLISH TASK FORCE.—The Secretary of Veterans Affairs shall establish a task force to recommend policies and legislation for the elimination of inconsistencies among provisions of law relating to veterans' eligibility for certain health-care benefits.

(b) COMPOSITION OF TASK FORCE.—The task force shall be composed of employees of the Department of Veterans Affairs, including representatives of the Veterans Health Services and Research Administration, the Veterans Benefits Administration, and the Office of the General Counsel.

(c) RESPONSIBILITIES OF TASK FORCE.—The task force shall—

(1) identify inconsistencies among sections 601(6), 612, 614, 617, and 619 of title 38, United States Code, and the implementation of such sections;

(2) after consultation with appropriate representatives of veterans, develop policy recommendations and legislative proposals for the elimination of any such inconsistencies; and

(3) not later than the date specified by the Secretary, submit to the Secretary a report containing (A) descriptions of the inconsistencies identified by the task force, (B) the policies and legislative proposals recom-

mended by the task force for the elimination of such inconsistencies, and (C) the reasons for each such recommendation.

(d) ACTION BY THE SECRETARY.—The Secretary shall review the report submitted by the task force and either approve the recommendations for legislation contained in the report or prepare alternative legislative proposals that the Secretary considers appropriate for the elimination of the inconsistencies identified by the task force.

(e) SUBMISSION OF RECOMMENDATIONS TO CONGRESS.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives—

(1) the report submitted to the Secretary by the task force; and

(2) a report containing—

(A) the legislation recommended by the Secretary for the elimination of the inconsistencies identified by the task force;

(B) an analysis of the legislation recommended by the Secretary; and

(C) the reasons for any differences between the legislation recommended by the Secretary and the legislation recommended by the task force.

○

101st CONGRESS
1st Session

S. 165

To require the Administrator of Veterans Affairs to construct a medical research center for the Veterans Administration and the Medical University of South Carolina in Charleston, South Carolina.

IN THE SENATE OF THE UNITED STATES

January 25 (legislative day, January 3), 1989

Mr. Thurmond introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To require the Administrator of Veterans Affairs to construct a medical research center for the Veterans Administration and the Medical University of South Carolina in Charleston, South Carolina.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CONSTRUCTION OF MEDICAL RESEARCH CENTER FOR THE VETERANS ADMINISTRATION AND THE MEDICAL UNIVERSITY OF SOUTH CAROLINA, CHARLESTON, SOUTH CAROLINA.

(a) Construction Required.—Subject to subsection (b), the Administrator of Veterans Affairs shall construct, at the Veterans Administration Medical Center and the Medical University of South Carolina in Charleston, South Carolina, a building to be used as a medical research center and shall appropriately equip such building for such use. The Administrator shall construct such building only on land provided by the Medical University of South Carolina.

(b) COST-SHARING ARRANGEMENT.—(1) The construction and equipping of a medical research center pursuant to subsection (a) may be carried out only if the Administrator of Veterans Affairs, the President of the Medical University of South Carolina, and the Governor of South Carolina enter into a funding agreement described in paragraph (2).

(2) Any funding agreement referred to in paragraph (1) shall provide for—

(A) the Administrator to pay one-half of the cost of constructing and equipping the medical research center authorized by subsection (a); and

(B) the State of South Carolina and the Medical University of South Carolina to pay one-half of such cost.

(3) The Administrator may include in any such funding agreement such terms and conditions as the Administrator considers necessary to protect the interests of the United States.

(4) The Administrator may accept payments from the State of South Carolina and the Medical University of South Carolina pursuant to the funding agreement and apply the amounts so paid to defray the cost of constructing and equipping the medical research center pursuant to subsection (a).

SEC. 2. PURPOSE OF THE MEDICAL RESEARCH CENTER.

Any medical research center constructed pursuant to section 1 shall be used for medical research activities, including medical research regarding geriatrics, diabetes, heart disease, arthritis, and connective tissue disorders.

SEC. 3. JOINT OWNERSHIP, MANAGEMENT, AND USE OF MEDICAL RESEARCH CENTER.

The Administrator may enter an agreement with the President of the Medical University of South Carolina that provides for joint ownership, management, and use of the medical research center by the Veterans Administration and the Medical University of South Carolina. The Administrator may include in any such agreement such terms and conditions as the Administrator considers necessary to protect the interests of the United States.

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

(a) AMOUNT AUTHORIZED.—There is hereby authorized to be appropriated $12,000,000 for the Veterans Administration share of the cost of carrying out section 1.

(b) AVAILABILITY.—Funds appropriated pursuant to subsection (a) shall remain available until expended.

○

101st CONGRESS
1st Session

S. 573

To amend title 38, United States Code, to provide for third-party reimbursement of the United States for the cost of health care and services furnished a service-connected disabled veteran by the Department of Veterans Affairs for a non-service-connected disability.

IN THE SENATE OF THE UNITED STATES

March 15 (legislative day, January 3), 1989

Mr. Murkowski (for himself, Mr. Simpson, and Mr. Jeffords) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to provide for third-party reimbursement of the United States for the cost of health care and services furnished a service-connected disabled veteran by the Department of Veterans Affairs for a non-service-connected disability.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. THIRD-PARTY REIMBURSEMENT FOR THE COST OF CERTAIN DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE.

Section 629(a)(2) of title 38, United States Code, is amended by striking out clause (D) and inserting in lieu thereof the following:

"(D) that is incurred by a veteran who is entitled to care (or payment of the expense of care) under a health-plan contract.".

SEC. 2. EFFECTIVE DATE.

The amendment made by section 1 shall take effect with respect to care and services furnished a veteran under chapter 17 of title 38, United States Code, on or after the date of the enactment of this Act.

○

101st CONGRESS
1st Session

S. 574

To amend title 38, United States Code, to improve health care benefits for veterans.

IN THE SENATE OF THE UNITED STATES

March 15 (legislative day, January 3), 1989

Mr. Murkowski (for himself, Mr. Simpson, and Mr. Jeffords) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to improve health care benefits for veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Health-Care Program Improvements Amendments of 1989".

SEC. 2. REFERENCE TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 3. DEFINITIONS.

Section 101 is amended—

(1) by striking out paragraph (1) and inserting in lieu thereof the following:

"(1) The terms 'Administrator' and 'Secretary' mean the Secretary of Veterans Affairs (except when the context indicates otherwise)."; and

(2) by adding at the end the following:

"(33) The term 'Department' means the Department of Veterans Affairs (except when the context indicates otherwise).".

SEC. 4. ASSISTIVE ANIMALS FOR CERTAIN DISABLED VETERANS.

(a) IN GENERAL.—(1) Section 614 is amended by adding at the end the following new subsection:

"(c) The Secretary may provide simians and dogs specially trained as assistive animals to any veteran who, by reason of quadriplegia, is entitled to disability compensation, and may pay travel and incidental expenses (under the terms and conditions set forth in section 111 of this title) to and from such veteran's home that are incurred in connection with the veteran becoming adjusted to such simians or dogs, as the case may be.".

(2)(A) The heading of section 614 of title 38, United States Code, is amended by striking out **"seeing-eye dogs"** and inserting in lieu thereof **"assistive animals"**.

(B) The table of sections at the beginning of chapter 17 is amended by striking out the item relating to section 614 and inserting in lieu thereof the following:

"614. Fitting and training in use of prosthetic appliances; assistive animals.".

(b) EVALUATION AND REPORT.—(1) Not later than October 1, 1992, the Secretary of Veterans Affairs shall evaluate the implementation of section 614(c) of title 38, United States Code (as added by subsection (a)), and submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the experience of the Department of Veterans' Affairs in providing assistive animals to veterans under such section.

(2) The report shall—

(A) set forth the Secretary's evaluation, findings, and conclusions regarding the implementation of such section through September 30, 1992, and the results of providing assistive animals to veterans under such section; and

(B) include a description of the implementation of such section (including a description of the veterans provided assistive animals under such section) and any plans for administrative action, and any recommendations for legislation, that the Secretary considers appropriate to include in the report.

SEC. 5. REPEAL OF AUTHORITY TO FURNISH TOBACCO TO VETERANS RECEIVING HOSPITAL OR DOMICILIARY CARE.

(a) IN GENERAL.—Section 615 is repealed.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by striking out the item relating to section 615.

SEC. 6. EXTENSION OF AUTHORITY TO FURNISH RESPITE CARE.

(a) IN GENERAL.—Section 620B(c) is amended by striking out "1989" and inserting in lieu thereof "1991".

(b) EXTENSION OF DEADLINE FOR REPORT.—Section 201(b)(2) of the Veterans Benefits Improvement and Health-Care Authorization Act of 1986 (Public Law 99-576; 100 Stat. 3254; 38 U.S.C. 620B note) is amended by striking out "1989" and inserting in lieu thereof "1990".

SEC. 7. NONINSTITUTIONAL ALTERNATIVES TO NURSING HOME CARE.

(a) AUTHORITY TO PROVIDE FOR NONINSTITUTIONAL CARE.—(1) Subchapter II of chapter 17 is amended by adding at the end the following new section:

“§ 620C. Noninstitutional alternatives to nursing home care

“(a) The Secretary shall establish a program for the furnishing of medical, rehabilitative, and health-related services in noninstitutional settings for veterans who—

“(1) are eligible under this chapter for nursing home care; and

“(2) are in receipt of or in need of nursing home care primarily for the treatment of a service-connected disability.

“(b)(1) Under the program established pursuant to subsection (a), the Secretary shall (A) furnish appropriate health-related services solely through contracts with appropriate public and private agencies that provide such services, and (B) in the case of each veteran furnished services under the program, appoint a Department of Veterans Affairs health-care employee to furnish case management services.

“(2) For the purposes of paragraph (1) of this subsection, ‘case management’ includes the coordination and facilitation of all services furnished to a veteran by the Department of Veterans Affairs, either directly or through contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the Department, either directly or through a contract, or by an entity other than the Department) monitoring, reassessment, and follow up.

"(c) The Secretary may provide in-kind assistance (through the services of Department of Veterans Affairs employees and the sharing of other Department resources) to a facility furnishing services to veterans under subsection (b)(1)(A) of this section. Any such in-kind assistance shall be provided under a contract between the Department and the facility concerned. The Secretary may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Department receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the Department facility that provided the assistance.

"(d) The total cost of conducting the program under this section in any fiscal year may not exceed 65 percent of the cost that would have been incurred by the Department during such fiscal year if the veterans furnished services under the program in that fiscal year had been furnished, instead, nursing home care under section 610 of this title.".

(2) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 620B the following new item:

"620C. Noninstitutional alternatives to nursing home care.".

(b) REPORT.—Not later than December 31, 1992, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report setting forth the Secretary's evaluation, findings, and conclusions regarding the conduct, through September 30, 1992, of the program established under section 620C of title 38, United States Code (as added by subsection (a)), and the results of the furnishing of care under such program for the participating veterans. The report shall include a description of the conduct of the program (including a description of the veterans furnished services and of the services furnished under the program), and any plans for administrative action, and any recommendations for legislation, that the Secretary considers appropriate to include in the report.

SEC. 8. PAY ENHANCEMENTS FOR DEPARTMENT OF VETERANS AFFAIRS NURSING ASSISTANTS AND NURSES.

(a) PREMIUM PAY FOR CERTAIN NURSING ASSISTANTS.—Section 4107(f) is amended by inserting "nursing assistants," in the second sentence after "vocational nurses,".

(b) WAIVER OF REDUCTION IN RETIRED OR RETAINER PAY.—Section 4107(i) is amended by inserting "or registered nurse" after "physician".

SEC. 9. EFFECTIVE DATE.

This Act and the amendments made by this Act shall take effect on October 1, 1989.

○

101st CONGRESS
1st Session

S. 748

To amend title 38, United States Code, and other provisions of law, to extend the authority of the Department of Veterans' Affairs (VA) to continue the State home grant and respite care programs and to revise VA authority to furnish outpatient dental care.

IN THE SENATE OF THE UNITED STATES

April 11 (legislative day, January 3), 1989

Mr. Cranston (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, and other provisions of law, to extend the authority of the Department of Veterans' Affairs (VA) to continue the State home grant and respite care programs and to revise VA authority to furnish outpatient dental care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Department of Veterans' Affairs Health Care Programs Extension Act of 1989".

(b) Except as otherwise expressly provided, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 2. (a) Section 612(b)(1) is amended—

(1) by striking out "or" at the end of subparagraph (F);

(2) by striking out the period at the end of subparagraph (G) and inserting in lieu thereof "; or"; and

(3) by adding at the end the following new subparagraph:

"(H) where medically necessary in preparation for hospital admission.".

(b) Section 612(b)(3) is amended—

(1) by striking "$500" and inserting in lieu thereof "$1,000"; and

(2) by adding at the end the following: "The Secretary may periodically review the cost of dental care to determine whether the dollar ceiling contained in this clause remains appropriate to carry out the purposes of this provision, and may adjust that ceiling, as the Secretary determines necessary.".

SEC. 3. Section 620B(c) is amended by striking "1989" and inserting in lieu thereof "1991".

SEC. 4. The first sentence of section 5033(a) is amended to read as follows: "There is hereby authorized to be appropriated $42,000,000 for the fiscal year ending September 30, 1990, and such sums as may be necessary for each of the four succeeding fiscal years.".

SEC. 5. Section 201(b) of Public Law 99-576 is amended by deleting "1989" and inserting in lieu thereof "1991".

○

101st CONGRESS
1st Session

S. 899

To amend title 38, United States Code, to authorize the Secretary of Veterans' Affairs to establish and conduct, for five years, a leave sharing program for medical emergencies of employees of the Department of Veterans' Affairs who are subject to section 4108 of title 38, United States Code.

IN THE SENATE OF THE UNITED STATES

MAY 2 (legislative day, JANUARY 3), 1989

Mr. CRANSTON (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to authorize the Secretary of Veterans' Affairs to establish and conduct, for five years, a leave sharing program for medical emergencies of employees of the Department of Veterans' Affairs who are subject to section 4108 of title 38, United States Code.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 4108 of title 38, United States Code is amended by adding at the end thereof the following new subsection:

"(e) The Secretary of Veterans' Affairs may establish and conduct, for five years, a leave sharing program for medical emergencies, covering employees subject to this section, which is consistent with the five-year leave sharing program authorized in subchapters III and IV of chapter 63 of title 5, United States Code, for employees appointed under that title."

SEC. 2. Subsection (e) of section 4108 of title 38, United States Code, is repealed effective October 31, 1993.

○

101st CONGRESS
1st Session

S. 900

To amend title 38, United States Code, to extend for one year the authorization of the Veterans' Administration to furnish respite care to certain chronically ill veterans and the due date for a report on the results of an evaluation of furnishing such care.

IN THE SENATE OF THE UNITED STATES

May 2 (legislative day, January 3), 1989

Mr. Rockefeller (for himself and Mr. Cranston) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to extend for one year the authorization of the Veterans' Administration to furnish respite care to certain chronically ill veterans and the due date for a report on the results of an evaluation of furnishing such care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 620B(c) of title 38, United States Code, is amended by striking out "September 30, 1989" and inserting in lieu thereof "September 30, 1990".

(b) Section 201(b)(2) of the Veterans' Benefits Improvement and Health-Care Authorization Act of 1986 (Public Law 99-576; 100 Stat. 3254) is amended by striking out "February 1, 1989" and inserting in lieu thereof "February 1, 1990".

○

101st CONGRESS
1st Session

S. 947

To amend title 38, United States Code, to improve conditions of employment for employees of the Veterans Health Services and Research Administration, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 9 (legislative day, JANUARY 3), 1989

Mr. CRANSTON (for himself, Mr. MITCHELL, Mr. MATSUNAGA, Mr. DECONCINI, Mr. ROCKEFELLER, Mr. GRAHAM, Mr. INOUYE, Mr. KOHL, Mr. PELL, Mr. WIRTH, and Mr. KERRY) introduced the following bill; which was read twice and referred to the Committee on Veterans Affairs

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A BILL

To amend title 38, United States Code, to improve conditions of employment for employees of the Veterans Health Services and Research Administration, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Health-Care Personnel Act of 1989".

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—PAY MATTERS

SEC. 101. PAY RATES FOR NURSES AND OTHER HEALTH-CARE PROFESSIONALS IN CERTAIN POSITIONS.

(a) IN GENERAL.—(1) Chapter 73 is amended by inserting after section 4107 the following new section:

"§ 4107A. Competitive pay rates for certain nurse and other health-care professional positions

"(a)(1) It is the purpose of this section to ensure, by a means providing maximum flexibility to directors of Department of Veterans Affairs health-care facilities, that the rates of basic pay for health-care professional positions described in paragraph (2) of this subsection in each such facility (including the rates of basic pay of personnel employed in such positions on a parttime basis) are sufficient for such health-care facility to be competitive, on the basis of pay and other employee benefits, with non-Department health-care facilities in the recruitment and retention of qualified personnel for such positions.

"(2) The health-care professional positions referred to in paragraph (1) of this subsection are registered nurse positions, registered nurse anesthetist positions, certified registered nurse anesthetist positions, and the positions for such other health-care professionals referred to in clauses (1) and (3) of section 4104 of this title as the Secretary may determine upon the recommendation of the Chief Medical Director.

"(b) The Secretary shall ensure that, for pay periods beginning on or after July 1, 1990, the rates of basic pay for covered positions in the Department are established in accordance with this section instead of section 4107(b)(1) of this title.

"(c)(1) Not later than June 1, 1990, the director of each Department health-care facility shall, with respect to the covered positions in each category of covered positions—

"(A) conduct a survey in accordance with this subsection; and

"(B) on the basis of such survey, establish the rates of basic pay in each pay grade provided for such positions in accordance with this section as necessary to carry out the purpose of this section.

"(2) The rates of basic pay established pursuant to paragraph (1) of this subsection shall become effective beginning with the first pay period that begins on or after July 1, 1990.

"(3) Not later than December 1 of each year after 1989, the director of each Department health-care facility shall, with respect to the covered positions in each category of covered positions—

"(A) conduct a survey in accordance with this subsection; and

"(B) on the basis of such survey—

"(i) determine whether it is necessary to adjust the rates of basic pay for such covered positions at such facility in order to carry out the purpose of this section; and

"(ii) effective with the first pay period that begins on or after January 1 of the next year, adjust the rates of basic pay in each pay grade provided for such positions in accordance with this section as necessary to carry out such purpose.

"(4)(A) In the case of the covered positions in each category of covered positions in a Department health-care facility, the director of that facility shall survey the entry-level compensation established for the corresponding health-care professional positions in comparable non-Department health-care facilities within the same labor market area as that Department health-care facility. The Secretary shall specify in regulations the criteria for determining the number of comparable non-Department health-care facilities to be included in the survey.

"(B) If the number of non-Department health-care facilities comparable to a Department health-care facility in the same labor market area is less than the number determined in accordance with the criteria specified pursuant to subparagraph (A) of this paragraph or is less than the director of that Department health-care facility considers necessary in order to produce a valid comparison, such director shall, in the case of the covered positions referred to in such subparagraph, survey—

"(i) the entry-level compensation established for the corresponding health-care professional positions in such comparable non-Department health-care facilities as are located within that labor market area; and

"(ii) the entry-level compensation established for the corresponding health-care professional positions in other non-Department health-care facilities within that labor market area.

"(C) For the purposes of this paragraph, a non-Department health-care facility is comparable to a Department health-care facility if the director of the Department health-care facility determines, in accordance with regulations prescribed by the Secretary, that the non-Department health care facility (i) is in direct competition with the Department health-care facility for the recruitment and retention of personnel qualified for employment in covered positions, and (ii) has other characteristics that are comparable to the characteristics of a Department health-care facility.

"(d)(1) If the director of a Department health-care facility determines in any year that, because of an insufficiency in the number of non-Department health-care facilities or non-Department covered positions, a survey under subsection (c) of this section would not provide a valid comparison with respect to the covered positions in the director's facility, the director shall establish or adjust the rates of basic pay for the covered positions in the director's facility as provided in this subsection instead of subsection (c) of this section.

"(2) Not later than 90 days before the date on which the director of a Department health-care facility establishes or adjusts rates of basic pay pursuant to paragraph (1) of this subsection, the director shall—

"(A) identify a labor market area that is similar to the labor market area of such facility and includes a Department health-care facility; and

"(B) notify the Chief Medical Director of the labor market identified pursuant to clause (A) of this paragraph.

"(3) The director of a health-care facility referred to in paragraph (1) of this subsection shall prescribe the same rates of basic pay for the covered positions in the director's facility as are prescribed for the same covered positions in the Department health-care facility located in the identified labor market area unless the selection of that labor market area for the purpose of this subsection is disapproved by the Chief Medical Director in accordance with paragraph (5) of this subsection.

"(4) If the Chief Medical Director disapproves (in accordance with paragraph (5) of this subsection) the selection of a labor market area by the director of a health-care facility for the purpose of this subsection, the director of that facility shall prescribe the same rates of basic pay for the covered positions in that facility as are prescribed for the Department health-care facility in a labor market area which the Chief Medical Director shall designate. The Chief Medical Director may designate any labor market area that the Chief Medical Director determines to be similar to the labor market area of the director's health-care facility.

"(5) Not later than 60 days after receiving a notification from the director of a Department health-care facility under paragraph (2)(B) of this subsection, the Chief Medical Director shall—

"(A) approve the selection of the labor market area identified in the notification; or

"(B) disapprove the selection of that labor market area, designate another labor market area determined by the Chief Medical Director to be similar to the labor market area of the director's health-care facility, and notify that facility director of that designation.

"(6) In order for a labor market area to be determined similar to the labor market area of a Department health-care facility for the purposes of this subsection, both labor market areas must be similar in size, demographic characteristics, and labor market characteristics.

"(e)(1) When the director of a Department health-care facility establishes or adjusts the rates of basic pay for a grade for any category of positions at such facility in order to carry out the purpose of this section, the director shall specify the minimum rate of basic pay for such grade and, subject to paragraph (3) of this subsection, increase or reduce the other rates of basic pay for such grade to amounts that bear the same relationship to the specified minimum rate of basic pay and to each other as the rates of basic pay within such grade bear to each other before the increase or reduction, as the case may be.

"(2) The minimum rate of basic pay prescribed for a grade for the positions in any category of covered positions in a Department health-care facility on the basis of a survey conducted under subsection (c) of this section shall be sufficient for the pay and other employee benefits of the health-care professionals employed in such positions in such grade to be competitive with the entry-level compensation (but may not exceed the highest rate of entry-level pay established) for the corresponding health-care professional positions in non-

Department health-care facilities in the same labor market area, as ascertained by the director of such facility in such survey.

"(3)(A) Except as provided in subparagraph (C) of this paragraph, the maximum rate of basic pay for any grade designated by the Secretary, upon the recommendation of the Chief Medical Director, as the entry-level grade for any category of covered positions may not exceed the maximum rate of basic pay established for grade 13 of the General Schedule under section 5332 of title 5.

"(B) The maximum rate of basic pay for any grade other than an entry-level grade for any category of covered positions may not exceed the maximum rate of basic pay established for a position in level V of the Executive Schedule under section 5316 of title 5.

"(C) The limitation prescribed by subparagraph (A) of this paragraph shall not apply to the entry-level grade for any category of covered positions if the positions have been designated by the Chief Medical Director as supervisory or managerial positions. The maximum rate prescribed by subparagraph (B) of this paragraph shall apply to such entry-level grade.

"(4) Whenever a grade is added to the schedule of grades for covered positions in any category of covered positions or a step within grade is added to a grade in such schedule, the director of a Department health-care facility shall establish the rates of basic pay for that grade or the rate of pay for that step, as the case may be, in the same manner as the rates of pay are established and adjusted under the other provisions of this subsection. The rates of basic pay for the additional grade shall bear the same relationship to the minimum rate of basic pay specified for such grade and to each other as the rates of basic pay within each other grade in such schedule bear to each other. The rate of pay for an additional step within grade shall bear the same relationship to the other rates of basic pay within such grade as such other rates bear to each other.

"(f) An employee who is paid a rate of basic pay established under this section and who is transferred (voluntarily or otherwise) from a covered position in one Department health-care facility to a covered position in another Department health-care facility shall be paid the rate of basic pay in effect for the covered position at the health-care facility to which the employee is transferred for the same grade and the same step within that grade as was applicable to that employee immediately before the transfer if the Chief Medical Director determines that the duties of the position to which the employee is transferred are at least comparable to the duties of the position from which the employee was transferred.

"(g)(1) Rates of basic pay may be increased or reduced under this section.

"(2) A reduced rate of basic pay established for a covered position under this subsection shall not apply to an employee serving in such position at a Department health-care facility on the day before the effective date of the reduced rate. That employee shall continue to be paid at a rate of basic pay not less than the rate of basic pay applicable to that employee on such day for as long as the employee continues to serve in such position at such facility.

"(h) The establishment and adjustment of rates of basic pay under this section for covered positions does not limit the authority of the Secretary to pay bonuses under section 4120 of this title to employees appointed to such positions.

"(i)(1) Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report regarding the exercise of the authority provided in this section for the immediately preceding calendar year.

"(2) The report shall contain an assessment of the effects of the exercise of such authority on the ability of the Department to recruit and retain qualified health-care professionals for covered positions. The Secretary shall include in the report recommendations for such additional legislation to facilitate the recruitment and retention of qualified health-care professionals for such positions as the Secretary determines necessary or appropriate.

"(3) If the authority provided in this section was exercised for the year covered by the report only to adjust the rates of basic pay for nurse positions, the report shall also contain the reasons that rates of basic pay were not adjusted for other health-care professional positions under such authority for such year and any plans for adjusting the rates of basic pay for other health-care professional positions under such authority.

"(j)(1) The Secretary, upon the recommendation of the Chief Medical Director, shall prescribe regulations setting forth criteria and procedures to carry out this section. Such regulations shall provide maximum flexibility for the director of each Department health-care facility. Documentation requirements in such regulations shall be minimal.

"(2) If the Secretary fails to prescribe final regulations under this subsection before April 1, 1990, the Secretary shall, not later than such date, prescribe interim final regulations for the purposes of this subsection. Such regulations shall be effective upon issuance and shall remain in effect until the effective date of final regulations issued for the purposes of this subsection.

"(3) If neither final regulations nor interim final regulations are prescribed under this subsection before April 1, 1990, the director of each Department health-care facility shall, nevertheless, make determinations and establish and adjust rates of basic pay under this section with respect to covered positions in such facility for 1990 and subsequent years. In the case of any determination or other action which is subject to criteria or procedures to be prescribed in such regulations, the director of each such facility shall apply such criteria and follow such procedures as the director considers appropriate and consistent with this section. Each such director shall apply the final regulations when issued.

"(k) For the purposes of this subsection:

"(1) The term 'covered position' means a position referred to in subsection (a)(1) of this section.

"(2) The term 'health-care facility' means a hospital or an independent outpatient clinic.

"(3) The term 'entry-level compensation', with respect to corresponding health-care professional positions in non-Department health-care facilities, means—

"(A) the minimum rate of pay established for professionals in such positions with education, training, and experience equivalent or similar to the education, training, and experience required for health-care professionals employed in the same category of Department covered positions; and

"(B) the other pecuniary employment benefits, if any, provided for the non-Department health-care professionals paid such minimum rate of pay.

"(4) The term 'corresponding', with respect to health-care professional positions in non-Department health-care facilities, means those positions for which the education, training, and experience requirements are equivalent or similar to the education, training, and experience requirements for health-care professional positions in Department health-care facilities.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 4107 the following new item:

"4107A. Competitive pay rates for certain nurse and other health-care professional positions.".

(b) TERMINATION OF APPLICABILITY OF REQUIREMENT TO SET PAY RATES BY EXECUTIVE ORDER.—Section 4107(b)(1) is amended by striking out "The" at the beginning of such section and inserting in lieu thereof "Except in the case of rates of basic pay subject to adjustment under section 4107A of this title, the".

(c) RELATIONSHIP OF PAY RATES TO ADDITIONAL PAY.—Section 4107(e)(1) is amended by striking out "in subsection (b)(1) of this section".

(d) GRADES FOR NURSE PAY SCHEDULE.—(1) Section 4107(b)(1) is amended by striking out the items under the heading "NURSE SCHEDULE" and inserting in lieu thereof the following:

"Three or more grades, as prescribed by the Chief Medical Director pursuant to paragraph (3) of this subsection.".

(2) Section 4107(b) is amended by adding at the end the following new paragraph:

"(3) The Chief Medical Director shall prescribe the number of grades and the number of steps within grades for nurse positions.".

(e) INTERIM COMPETITIVE PAY RATES.—(1) The director of each Department of Veterans Affairs health-care facility located in a rural area—

(A) shall, not later than December 1, 1989, conduct a survey consistent with the provisions of section 4107A(c) of title 38, United States Code (as added by subsection (a)); and

(B) pursuant to the authority provided in section 4107(g) of such title (as amended by section 105)—

(i) shall decide, not later than January 1, 1990, on the basis of the survey referred to in clause (A), whether to adjust, on a local basis, the rates of basic pay for nurses employed by the Department of Veterans Affairs; and

(ii) if deciding to adjust such rates on a local basis, shall adjust such rates effective for pay periods beginning after January 1, 1990, and before July 1, 1990.

(2) In conducting the survey referred to in paragraph (1), the director of a health-care facility located in a rural area shall include in such survey the rates of pay paid to nurses who reside in such area, who are employed in a health-care facility located outside such area, and who commute to work from such area to such health-care facility, if the director determines that the number of nurses who commute to work outside the area adversely affects the ability to employ nurses in the health-care facility of the director.

(3) For the purposes of this subsection—

(A) the term "health-care facility" has the meaning given such term in section 4107A(l) of title 38, United States Code (as added by subsection (a)); and

(B) the term "rural area" means a geographic area that the Secretary determines, upon the recommendation of the Chief Medical Director, to be a rural area.

(f) FIRST REPORT.—The first report under section 4107A(i) of title 38, United States Code (as added by subsection (a)), shall be submitted not later than March 1, 1991.

(g) CONFORMING AMENDMENT.—Section 101 is amended by adding at the end the following new paragraphs:

"(33) The term 'Secretary' means the Secretary of Veterans Affairs (except when the context indicates otherwise).

"(34) The term 'Department' means the Department of Veterans Affairs (except when the context indicates otherwise).".

SEC. 102. OVERTIME RATES OF PAY FOR CERTAIN NURSES.

(a) IN GENERAL.—Section 4107(e)(5) is amended by striking out the first sentence and inserting in lieu thereof the following: "A nurse who performs officially ordered or approved hours of service in excess of forty hours in an administrative workweek, or in excess of eight hours in a day, shall receive overtime pay for each hour of such additional service. The rate of overtime pay for such nurse shall be one and one-half times such nurse's hourly rate of basic pay.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect with respect to overtime service performed on or after October 1, 1989.

SEC. 103. ADDITIONAL PAY FOR HEAD NURSES.

(a) IN GENERAL.—Section 4107(e) is amended by adding at the end the following new paragraph:

"(11) A nurse shall be paid additional pay equal to 6 percent of the nurse's hourly rate of basic pay for each hour of service performed as a head nurse. The preceding sentence shall not apply to a nurse who is assigned to perform service as a head nurse for a period of less than 30 consecutive days.".

(b) Relationship to Basic Pay.—Paragraph (1) of section 4107(e) is amended by inserting "and (11)" after "(8)".

(c) Computation of Hourly Rate of Pay.—Paragraph (6) of section 4107(e) is amended by striking out "or (5)" and inserting in lieu thereof "(5), or (11)".

(d) Relationship to Other Additional Pay.—Paragraph (7) of section 4107(e) is amended by striking out "or (5)" and inserting in lieu thereof "(5), or (11)".

(e) Additional Pay as Head Nurse To Be Counted for Certain Benefits.—Paragraph (9) of section 4107(e) is amended by inserting ", other than pay under paragraph (11) of this subsection," after "this subsection".

(f) Technical Amendment.—Paragraph (9) of section 4107(e) is further amended by inserting "84," after "83,".

(g) Effective Date.—The amendments made by subsections (a) through (d) shall take effect with respect to service performed as a head nurse on or after October 1, 1989.

SEC. 104. WAIVER OF REDUCTION IN RETIRED OR RETAINER PAY FOR REGISTERED NURSES.

Section 4107(i) is amended by striking out "physician positions" and inserting in lieu thereof "(A) physician positions, (B) positions of health-care professionals involved in providing direct patient care, or (C) positions of personnel involved in providing services incident to direct patient care".

SEC. 105. SPECIAL RATES OF PAY FOR CERTAIN EMPLOYEES IN THE VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION.

(a) INCREASE IN LIMITATION.—Section 4107(g)(3) is amended—

(1) by inserting "(A)" after "(3)";

(2) by inserting "by two times" after "exceed" the first place it appears; and

(3) by inserting at the end the following new subparagraph:

"(B) Whenever the amount of an increase under paragraph (1) of this subsection results in a rate of basic pay for a position being in an amount that is 94 percent or more of the maximum amount permitted under subparagraph (A) of this paragraph, the Secretary shall promptly notify the Committees on Veterans' Affairs of the Senate and House of Representatives of the increase and the amount thereof.".

(b) APPROVAL OF SPECIAL RATES OF PAY.—Section 4107(g)(4) is amended—

(1) in the first sentence, by striking out "ninety" and inserting in lieu thereof "45"; and

(2) by adding at the end the following new sentence: "If, prior to such effective date, the President approves such increase, the Secretary may advance the effective date to any date not earlier than the date of the President's approval.".

SEC. 106. CONSIDERATION OF PROFESSIONAL SPECIALTY CERTIFICATION.

Section 4107 is amended by adding at the end the following new subsection:

"(k)(1) Except as provided in paragraph (2) of this subsection, the Secretary shall pay each nurse who is recertified in the speciality in which the nurse is employed a lump-sum payment equal to 1 percent of the annual salary of the nurse (as of the time the nurse is recertified). The Secretary shall make such payment when the nurse is recertified.

"(2) A payment may not be paid to a recertified nurse under this subsection if the performance rating for such nurse for the latest rating period ending before the date of the recertification is less than satisfactory.

"(3) A special payment under this subsection shall not be considered as basic pay for the purposes of any provision of law referred to in section 4107(e)(9) of this title.".

TITLE II—OTHER PERSONNEL BENEFITS

SEC. 201. HEALTH-CARE PROFESSIONALS CASH AWARDS.

(a) AUTHORITY TO PAY CASH AWARDS.—(1) Subchapter I of chapter 73 is amended by inserting after section 4120 the following new section:

"§ 4120A. Cash awards for supervisors and managers

"(a) The Secretary shall establish by regulation a program under which the Secretary may pay a cash award to any Department employee referred to in section 4104(1) of this title who is a supervisor or manager.

"(b) The amount of a cash award shall be determined by the Secretary but may not be in an amount that is less than 5 percent or more than 20 percent of the basic pay of the employee.

"(c) The Secretary may not pay cash awards under this section in any fiscal year to more than 20 percent of the employees in any one category of employees referred to in section 4104(1) of this title.

"(d) Determinations of which employees are supervisors or managers shall be made in accordance with the regulations prescribed to carry out this section, except that for purposes of this section head nurses shall be considered supervisors.

"(e) A cash award under this section shall not be considered as basic pay for the purposes of any provision of law referred to in section 4107(e)(9) of this section.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 4120 the following new item:

"4120A. Cash awards for supervisors and managers.".

(b) EFFECTIVE DATE.—(1) The amendments made by subsection (a) shall take effect on October 1, 1989.

(2) Cash awards may be made under section 4120A of title 38, United States Code (as added by subsection (a)), only for service performed on or after October 1, 1988.

SEC. 202. DEPENDENT CARE ASSISTANCE PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Subchapter I of chapter 73, as amended by section 201, is further amended by inserting after section 4120A the following new section:

"§ 4120B. Dependent care assistance

"The Secretary shall establish and conduct a dependent care assistance program, which meets the requirements of section 129 of the Internal Revenue Code of 1986, for the care of dependents of employees in the Veterans Health Services and Research Administration.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter, as amended by section 201, is further amended by inserting after the item relating to section 4120A the following new item:

"4120B. Dependent care assistance.".

(c) IMPLEMENTATION REQUIREMENT.—The Secretary of Veterans Affairs shall implement the program provided for in section 4120B of title 38, United States Code (as added by subsection (a)), not later than June 1, 1990.

SEC. 203. LEAVE TRANSFERS AND LEAVE BANKS FOR CERTAIN HEALTH-CARE PROFESSIONALS.

(a) IN GENERAL.—Section 4108 is amended by adding at the end the following new subsection:

"(e)(1) The Secretary—

"(A) shall, subject to paragraph (6) of this subsection, establish a voluntary transfer of leave program for the benefit of health-care professionals referred to in the matter preceding clause (1) of subsection (a) of this section; and

"(B) may establish a voluntary leave bank program for the benefit of such health-care professionals.

"(2) To the maximum extent feasible—

"(A) the voluntary transfer of leave program shall provide the same or similar requirements and conditions as are provided for the program established by the Director of the Office of Personnel Management under subchapter III of chapter 63 of title 5; and

"(B) any voluntary leave bank program established pursuant to paragraph (1)(B) of this subsection shall be consistent with the requirements and conditions provided for agency leave bank programs in subchapter IV of such chapter.

"(3) The Secretary and the Director of the Office of Personnel Management may enter into an agreement that permits health-care professionals referred to in paragraph (1) of this subsection to participate in the leave transfer program established by the Director of the Office of Personnel Management under subchapter III of chapter 63 of title 5.

"(4) The Secretary and the Director of the Office of Personnel Management may enter into an agreement that permits health-care professionals referred to in paragraph (1) of this subsection to participate in any voluntary leave bank program established for other employees of the Department pursuant to subchapter IV of chapter 63 of title 5.

"(5) Participation of such health-care professionals in a voluntary transfer of leave program or a voluntary leave bank program pursuant to an agreement entered into under paragraph (3) or (4) of this subsection shall be subject to such requirements and conditions as may be prescribed in such agreement.

"(6) The Secretary is not required to establish a voluntary transfer of leave program for any personnel permitted to participate in a voluntary transfer of leave program pursuant to an agreement referred to in paragraph (3) of this subsection.".

(b) IMPLEMENTATION REQUIREMENT.—The Secretary of Veterans Affairs shall implement the programs provided for in subsection (e) of section 4108 of title 38, United States Code (as added by subsection (a)), not later than October 1, 1990.

TITLE III—HEALTH CARE EDUCATION

SEC. 301. HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM AWARDS.

(a) APPLICANT PRIORITY AND EQUITABLE ALLOCATION FOR NURSING DEGREE APPLICANTS.—Section 4312(b)(5) is amended to read as follows:

"(5) In selecting applicants for the Scholarship Program, the Secretary shall—

"(A) give priority to applicants who will be entering the final year in a course of training; and

"(B) ensure an equitable allocation of scholarships to persons enrolled in the second year of a program leading to an associate degree in nursing.".

(b) IMPLEMENTATION REQUIREMENT.—The Secretary of Veterans Affairs shall provide for the implementation of the amendment made by subsection (a) beginning with scholarships awarded under section 4312 of title 38, United States Code, in 1990.

SEC. 302. ASSISTANCE TO HEALTH-PERSONNEL EDUCATIONAL INSTITUTIONS.

(a) DEVELOPMENT OF NEW HEALTH CAREERS.—(1) Section 5091 is amended by inserting "(in collaboration with representatives of the professions the members of which are currently responsible for carrying out the duties involved)" after "paramedical personnel, and".

(2) The Secretary of Veterans Affairs shall prescribe interim final regulations for implementation of the amendment made by paragraph (1) not later than February 1, 1990.

(3) For the purposes of paragraph (2), the term "interim final regulations" means regulations that are in effect until the effective date of final regulations issued for implementation of the amendment made by paragraph (1).

(b) AUTHORIZATION OF APPROPRIATIONS FOR GRANTS.—(1) Subchapter III of chapter 82 is amended by adding at the end the following new section:

"§ 5094. Authorization of appropriations

"(a) There is authorized to be appropriated for the purpose of making grants under this subchapter $5,000,000 for each of fiscal years 1990 and 1991 and $6,000,000 for each of fiscal years 1992 and 1993.

"(b) The sum appropriated for a fiscal year pursuant to subsection (a) of this section shall remain available until the end of the fifth fiscal year following the fiscal year for which the sum is appropriated.

"(c) Of the funds appropriated for each fiscal year pursuant to the authorization in subsection (a) of this section, an amount not to exceed 10 percent of the sum so appropriated may be expended for the purpose described in section 5096(2) of this title.".

(2) The table of sections at the beginning of chapter 82 is amended by inserting after the item relating to section 5093 the following new item:

"5094. Authorization of appropriations.".

TITLE IV—OTHER PERSONNEL MANAGEMENT MATTERS

SEC. 401. EMPLOYMENT OF PERSONNEL TRAINED BY THE DEPARTMENT OF VETERANS AFFAIRS.

Section 4106 is amended by adding at the end the following new subsection:

"(h)(1) Notwithstanding subchapter I of chapter 33 of title 5, the Secretary, upon the recommendation of the Chief Medical Director, may appoint in the competitive service under such title any individual who—

"(A) has been awarded a degree or certificate in a health-care profession or occupation by an accredited institution;

"(B) has been appointed by the Secretary to participate in a clinical education program conducted by an educational institution affiliated with the Department health-care facility; and

"(C) within one year before that individual's appointment in the competitive service, has successfully completed such clinical education program.

"(2) In making appointments to the competitive service under this subsection, the Secretary shall apply the provisions in subchapter I of chapter 33 of title 5 that relate to preferences for the hiring of veterans and other persons.".

SEC. 402. PILOT PROGRAM OF PAY AND PERSONNEL MANAGEMENT PRACTICES.

(a) IN GENERAL.—The Chief Medical Director of the Department of Veterans Affairs shall conduct a pilot program at not less than five department medical centers during calendar years 1990, 1991, and 1992, in order to determine—

(1) the effects of pay and personnel management practices of the Veterans Health Services and Research Administration on the ability of the department to recruit and retain persons qualified to provide direct patient-care services or services incident to direct patient-care services in department health-care facilities as employees in employee position categories in which the department is experiencing recruitment and retention problems;

(2) whether it is desirable to establish programs which foster interdisciplinary professional collaboration and collegial relationships between physicians, regis-

tered nurses, and other employees providing direct patient care, and what effects such programs would have on the ability of the department to recruit and retain registered nurses;

(3) whether it is desirable to create new alternatives for utilizing the skills and knowledge of registered nurses in furnishing direct patient care, and what effects such alternatives would have on (A) the ability of the department to recruit and retain registered nurses, and (B) the cost of providing care to veterans;

(4) whether increasing the pay differential for evening and night shifts will attract adequate numbers of qualified workers for such shifts and result in more permanent day-shift assignments;

(5) whether it is desirable to revise the grade, classification, pay, and performance qualifications systems and any other appropriate personnel management systems for employees of the Administration; and

(6) whether it is desirable to establish flexible employment benefits programs for employees of the Administration.

(b) CONDUCT OF PILOT PROGRAM.—In conducting the pilot program under subsection (a), the Chief Medical Director shall—

(1) at not less than one site, establish a collaborative practice committee involving physicians, nurses, and, as appropriate, other direct health-care personnel;

(2) at not less than one site, significantly increase the pay differential for evening and night service;

(3) at not less than three sites, implement new alternatives for utilizing the skills and knowledge of registered nurses in the furnishing of direct-patient care;

(4) at not less than one site, establish systems alternative to or additional to the systems established under chapter 73 of title 38, United States Code, or chapters 33, 43, 51, 53, 54, and 61 of title 5, United States Code, for grade, classification, pay, performance, qualifications, and other appropriate aspects of personnel management; and

(5) at not less than one site, establish and administer flexible employment benefits programs as alternatives or additions to the programs established under chapter 73 of title 38, United States Code, or chapters 63, 79, 87, and 89 of title 5, United States Code.

(c) REPORTS.—(1)(A) Not later than June 30, 1991, the Chief Medical Director shall submit to the Secretary of Veterans Affairs a report on the experience under the pilot program during the first 12 months such program is conducted. The report shall contain—

(i) the Chief Medical Director's evaluation of the effect of each management practice undertaken in the pilot program on the ability of the Department of Veterans Affairs to recruit and retain health-care employees;

(ii) information on the cost factors associated with each such management practice;

(iii) an evaluation of the functioning and productivity of the employees involved in or affected in any substantial way by such practices;

(iv) a discussion of any effects on the quality and timeliness of care provided to veterans; and

(v) any planned administrative actions and any recommendations for legislation or administrative action that the Chief Medical Director considers appropriate to include in the report on the basis of the results of such pilot program.

(B) Not later than 60 days after receiving the report under subparagraph (A), the Secretary shall submit a copy of the report, together with any comments on the report and any recommendations for legislation that the Secretary considers appropriate, to the Committees on Veterans' Affairs of the Senate and the House of Representatives.

(2)(A) Not later than June 30, 1992, the Chief Medical Director shall submit to the Secretary a report on the experience under the pilot program during the first 24 months such program is conducted. In such report the Chief Medical Director shall update all information contained in the report submitted pursuant to paragraph (1)(A) and shall make any recommendations for legislation or administrative action that the Chief Medical Director considers appropriate.

(B) Not later than 60 days after receiving the report under subparagraph (A), the Secretary shall submit a copy of the report, together with any comments on the report and any recommendations for legislation that the Secretary considers appropriate, to the Committees on Veterans' Affairs of the Senate and the House of Representatives.

(3)(A) Not later than June 30, 1993, the Chief Medical Director shall submit to the Secretary a final report on the pilot program required by subsection (a). In such report the Chief Medical Director shall—

(i) update all information contained in the reports submitted pursuant to paragraphs (1)(A) and (2)(A) of this subsection;

(ii) make a final assessment of the pilot program based on the experience under the program during the 36 months for which the program was conducted; and

(iii) make any recommendations for legislation or administrative action that the Chief Medical Director considers appropriate.

(B) Not later than 60 days after receiving the report under subparagraph (A), the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a copy of the report together with—

(i) any comments on the report that the Secretary considers appropriate;

(ii) the Secretary's final assessment of the pilot program based on the experience under the program during the 36 months for which the program was conducted; and

(iii) any recommendations for legislation that the Secretary considers appropriate.

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101st CONGRESS
1st Session

S. 1004

To amend title 38, United States Code, and other provisions of law, to improve the administration of veterans' health care benefits and personnel management in the Department of Veterans' Affairs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

May 16, (legislative day, January 3), 1989

Mr. Cranston (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, and other provisions of law, to improve the administration of veterans' health care benefits and personnel management in the Department of Veterans' Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) Except as otherwise expressly provided, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

Sec. 2. Section 620(a)(2) is amended—

(a) by striking clause (A) and inserting in lieu thereof the following:

"(A) the amount equal to 45 percent of the cost of care furnished by the Department of Veterans' Affairs in a general hospital under the direct jurisdiction of the Department (as such cost may be determined annually by the Secretary) in the State in which such instituton is located;"

(b) by striking the period at the end of clause (B) and inserting "; or" in its place; and

(c) by inserting a new clause (C) as follows:

"(C) the amount equal to 50 percent of the cost of care furnished by a community general hospital under contract with the Department of Veterans' Affairs (as such cost may be determined annually by the Secretary) in Alaska or Hawaii."

SEC. 3. Section 628(a)(2) is amended by striking the word "found" and all that follows and inserting in lieu thereof "a participant in a vocational rehabilitation program as defined in section 1501(9) and is medically determined to have been in need of care or treatment to make possible such veteran's entrance into a rehabilitation program, or prevent interruption of a rehabilitation program, or hasten the return to a rehabilitation program which was interrupted because of such illness, injury, or dental condition; and".

SEC. 4. Section 4107(b)(2) is amended by striking the period at the end of the first sentence and inserting in lieu thereof the following: "or is a physician or dentist serving in a comparable position in the Central Office of the Veterans' Health Services and Research Administration."

SEC. 5. Section 4114(a)(3) is amended—

(a) by striking the penultimate sentence in paragraph (A) and inserting in lieu thereof the following: "Temporary full-time appointments of persons who have successfully completed a full course of training as a physical therapist, practical/vocational nurse, occupational therapist or pharmacist in a recognized school for that occupation, approved by the Secretary, and who are pending registration/licensure in a State or certification by a national board recognized by the Secretary, shall not exceed two years.".

(b) by inserting after the penultimate sentence in paragraph (C) the following: "A student who has a temporary appointment under this paragraph and who is pursuing an academic program leading to a degree in physical therapy, occupational therapy or pharmacy approved by the Secretary may be reappointed for a period not to exceed the duration of such student's academic program.".

SEC. 6. The section 4205 is amended—

(a) by striking the phrase "or other interest bearing accounts"; and

(b) by adding the following at the end: "Money in the revolving fund not required for current disbursements shall be invested and reinvested by the Secretary of the Treasury in interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States, taking into consideration current market yields on outstanding marketable obligations of the United States. The income on such investments shall be credited to and form a part of the Fund.".

SEC. 7. Section 4208 is amended by deleting the old text and inserting in lieu thereof: "Notwithstanding any other law, the Service shall be under the exclusive control and supervision of the Secretary, and shall: (1) function as an independent unit in the Department of Veterans' Affairs; (2) have exclusive control over all activities of the Service, including sales, procurement and supply, finance, including disbursements, and personnel management; and (3) have sole and exclusive authority to provide articles of merchandise and services, under this chapter, at any Department of Veterans' Affairs facility under the control or jurisidiction of the Secretary.".

(b) The table of sections at the beginning of chapter 75, title 38, United States Code, relating to section 4208 is amended to read as follows:

"4208. Service to be independent unit and exclusive."

SEC. 8. Section 115 of Public Law 100-322 is amended—

(a) by striking "1989" in subsections (d) and (e) and inserting in lieu thereof "1992";

(b) by striking "1988" in subsection (e) and inserting in lieu thereof "1991"; and

(c) by striking subsection (f) in its entirety and redesignating subsection "(g)" as "(f)".

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OPENING STATEMENT
SENATOR ALAN CRANSTON, CHAIRMAN
COMMITTEE ON VETERANS' AFFAIRS
HEARING ON HEALTH LEGISLATION OTHER THAN MENTAL HEALTH
SECTIONS 211, 213-215, AND 222-225 OF S. 13; S. 165; S. 573; S. 574; S. 748; S. 899; S. 900; AND S. 947

Good morning. I welcome all of you to this hearing to consider various bills focusing on Department of Veterans Affairs (VA) health-care issues. We are very grateful to those appearing today to provide us with your views on these measures. Testimony will cover a wide variety of subjects ranging from proposals related to furnishing direct health-care services to veterans to measures which provide for competitive pay and benefits for professionals furnishing those services.

Introduction

Even though VA is experiencing a severe budget shortfall which is creating a devastating cutback in services, programs, and personnel, we must continue to forge ahead in our efforts to provide VA with the tools, flexibility, and authorities needed to furnish quality health care while we are, concurrently, moving forward on the budget and appropriations fronts. We also must continue to monitor the health-care needs of our Nation's veterans -- to whom we owe such a great debt -- and offer them the very best that we can afford to meet their needs. We must also monitor closely the quality of care provided.

As author of S. 13, introduced on January 25, and S. 947, introduced on May 9, and cosponsor of S. 900, introduced on May 2, I will, of course, be very interested in the witnesses' views on these measures as well as on Senator Murkowski's bills, Senator Thurmond's bill, and those I introduced at the request of the Administration. Just this past Tuesday, I introduced for the Administration its health-care measure, S. 1004, transmitted to Congress on May 10.

Description of Legislation

S. 13: With more specific reference to S. 13, which is cosponsored by Senators Matsunaga, DeConcini, Rockefeller, Mitchell, Graham, Burdick, and Kerry, I will highlight those provisions about which we will be receiving testimony today. Sections 211, 213-15, and 225 have as their basic purpose the improvement of various programs of benefits and health-care services for veterans while sections 233 and 224 address concerns involving labor-management relations involving VA and those VA health-care employees employed under the title 38 personnel system.

Services to Overcome Service-Connected Disability Affecting Procreation: Section 211 of S. 13 would require VA to furnish services to help a male or a female veteran or a male veteran's spouse achieve pregnancy in cases in which the veteran's service-connected disability impairs procreative ability.

This authority is necessary because VA maintains that it does not have the authority to furnish medical services for service-connected disabilities that impair the ability to have children. This issue came to my attention in connection with the case of a woman who, while serving in the U.S. Air Force, developed pelvic inflammatory disease, which was misdiagnosed. The disease progressed, scarred her fallopian tubes, and left her sterile. Although she tried to convince VA to pay for in vitro fertilization -- the only procedure that offered her the possibility of having a child -- VA chose to interpret its statutory authority very narrowly and refused to provide the procedure, claiming that it lacked the authority to furnish such services.

Although I do not believe that VA's legal interpretation of its existing authority is correct, and did my utmost to bring about a change in that interpretation, I was not successful. Hence, this measure would expressly provide such authority, as well as a direction that it be exercised, to overcome a service-related procreative impairment in order to remove any doubts that may exist on this issue.

I note that this provision is the same as section 8 of S. 2388 and section 2 of S. 6, legislation which I authored in 1986 and 1987, respectively. These prior provisions were supported by all the major veterans organizations. Our committee favorably reported provisions derived from these measures in section 205 of S. 2422 and section 301 of S. 9, respectively, and both were subsequently passed by the Senate. Unfortunately, the House did not agree to these provisions on either occasion and they were not included in the measures which were ultimately enacted.

With further reference to the prior legislative history on this issue, I note that, on April 13, 1988, when S. 9 was discussed during the conference between the House and the Senate Veterans' Affairs Committee, our colleagues in the House proposed to preclude VA from furnishing certain medical procedures and were particularly adamant in insisting that IVF be excluded -- the procedure that could, as in the case of the Air Force woman veteran I just discussed, be the only available procedure for some women veterans. The Senate conferees could not accept that discriminatory result. I believe it is highly inappropriate for Congress to legislate how medicine should be practiced by dictating which medical procedures are acceptable and which are not. Although I am aware that individuals have differing moral or religious views on IVF, I strongly believe decisions about such medical procedures must be left to the individual. I do not believe that we should be setting public health policy according to one view or interpretation. Such a decision should be one that the individual veteran and his or her physician make.

State Home Construction Grants: VA operates two separate programs of assistance to State Veterans' Home hospital, nursing home, and domiciliary facilities: First, under subchapter V of chapter 17 of title 38, VA makes per diem payments to State Homes for care provided to eligible veterans; and, second, under subchapter V of chapter 17 of title 38, VA makes matching grants to states for the construction, remodeling, or renovation of State Home nursing home or domiciliary facilities. Section 213 of S. 13 would extend for three years, through September 30, 1992, the authorization to appropriate such sums as are necessary to carry out the construction grant program. Section 4 of the Administration bill, S. 748, would authorize $42-million to be appropriated for FY 1990 and such sums as may be necessary for each of the four succeeding fiscal years.

I strongly support the State Home program and its continuation as an important link in meeting the needs of our aging veteran population, and believe that continuing the authorization of appropriation for this program is fully warranted in light of its importance in the overall effort to meet the health-care needs of the aging veteran population. I note that last year a similar provision, extending the authorization of appropriations for the construction grant program for three years, through FY 1992, was favorably reported by our Committee as section 614 of S. 2011 and was passed by the Senate in H.R. 4741 on October 18, 1988. Although there was no disagreement on the House's part regarding the concept of extending this program, this provision was dropped when our Committees could not agree on other, unrelated health-care matters.

Sharing of Specialized Medical Resources: Section 222 of S. 13 contains several provisions relating to the sharing of specialized resources -- one to expand the categories of facilities with which VA could enter into sharing arrangements so as to encompass any health-care facility; a second, to provide the Secretary with the authority to enter into agreements with private-sector facilities based upon mutually agreed-upon methodologies for reimbursement which take into account local conditions and the needs and the actual costs to the providing agency's facility of the resources being provided; and a third to require the money received from such sharing to be returned to the VA facility involved in the sharing.

Subchapter IV of chapter 81 of title 38, relating to the sharing of medical facilities and information, was enacted in 1966 as part of Public Law 89-785 for the purpose, in part, of improving the care furnished to veterans. To do so, it authorized VA to enter into agreements with medical schools, hospitals, and research centers under which VA could receive from or share with these facilities specialized medical resources which might otherwise not be feasibly available or effectively utilized for veterans or others. Later, in 1979, legislation which I authored, section 304 of Public Law 96-151, expanded this authority to include sharing arrangements with organ banks, blood banks, or similar institutions.

Our current health-care environment has spawned a variety of entities furnishing community health care, and it is sometimes difficult to label or categorize them. I believe that if VA is to be able to take full advantage of sharing arrangements it must have the flexibility to enter into agreements with these new entities or entities which already exist but which are providing a different level of care than in the past.

Current law, section 5053(b) of title 38, requires that these sharing arrangements provide for "reciprocal reimbursement based on a charge which covers the full cost of services rendered, supplies used, and including normal depreciation and amortization costs of equipment." Contrasted with this strict, full-cost reimbursement approach, section 5011 of title 38 which relates to sharing agreements between VA and the Department of Defense, allows reimbursement to be based upon a mutually-agreed-upon methodology that provides appropriate flexibility to the heads of the facilities concerned to take into account local conditions and the needs and actual costs of the health-care resources provided. Under this approach, heads of VA and DOD medical facilities may negotiate a rate that is less than actual cost.

A March 1988 General Accounting Office report, GAO/HRD-88-51, entitled "VA/DOD Health Care -- Further Opportunities to Increase the Sharing of Medical Resources", noted that a misuse of the full-cost requirement set forth in section 5053(b) created a disincentive to sharing between VA and DOD where the amount of the full cost of the services is greater then the price at which the same services may be obtained in the community. It is reasonable to conclude that a similar impediment exists with respect to sharing between VA and private-sector facilities. Finally, requiring the money received from a sharing arrangement to be returned to the VA facility involved in the sharing would strengthen that facility's ability to provide health-care to veteran-patients and would provide an incentive to such sharing.

I note that this provision is the same as section 7 of S. 2462, legislation which I authored last year and which our Committee favorably reported in section 613 of S. 2011 and the Senate passed on October 18, 1988, in H.R. 4741. Unfortunately, although there was no disagreement about this particular provision, it was not included at the time of final passage. Matters pertaining to sharing agreements -- like the State home grant program provision I discussed earlier -- were dropped as a result of differences between the House and Senate Committees on Veterans' Affairs over unrelated health-care items.

Pilot Programs for Providing Veterans with Assistive Animals: Section 214 of S. 13 would establish a VA pilot program to provide assistive monkeys to certain quadriplegic veterans. Under the program, VA would be required to (a) provide such a monkey to not more than 20 veterans who are either entitled to compensation by reason of quadriplegia or have service-connected disabilities rated 50-percent or more disabling and are quadriplegic; and (b) to facilitate (through information and matching efforts) the provision of monkeys to not more than 20 other veterans with quadriplegia when funding for the purchase of the animals comes from a source other than VA. Priority for the provision of the monkeys, and for the facilitation of their provision, would be required to be given to veterans with service-connected quadriplegia.

Additionally, section 214 would require the Secretary of Veterans' Affairs to submit to the two Veterans' Affairs Committees an evaluation of the benefits, costs, and cost-effectiveness of providing monkeys to veterans who are quadriplegic; the views of the Secretary on the relationship between the provision of a monkey to a veteran and the payment to a veteran of an aid and attendance allowance in conjunction with the veteran's service-connected disability compensation or non-service-connected disability pension; and any recommendations that the Secretary considers appropriate regarding whether to extend the pilot program or to make the authority permanent.

Section 215 would provide for the establishment of a similar pilot program for the provision of "signal dogs" -- dogs specially trained to help deaf individuals overcome their hearing impairment by alerting them through non-aural means to sounds such as a telephone, fire alarm, doorbell, or child's cry -- if the Secretary determines that there is no authority otherwise to provide them. Up to this point, very few veterans have applied for signal dogs, and the authority to provide them seems to be unclear.

These provisions are nearly identical to the provision reported by the Committee in S. 2011. Although the Senate passed the provisions of

S. 2011, this provision was not acceptable to the House of Representatives, and was not enacted into law. I continue to believe this pilot program is a worthwhile and innovative way to help improve the quality of life for those veterans with high-level quadriplegia.

Section 4 of S. 574, Senator Murkowski's bill, would provide a permanent authority to provide simians and dogs specially trained as assistive animals to any veteran who, by reason of quadriplegia, is entitled to disability compensation, as well as the authority to pay for the veterans' travel and incidental expenses incurred in connection with the veterans' becoming adjusted to these assistive animals. S. 574 also calls for an evaluation of and report on this program by October 1, 1992.

Clearly, the use of assistive monkeys is novel and a number of questions exist as to the extent to which and conditions under which they should be provided by VA. Hence, I believe that it would be best to gain some experience with the use of assistive monkeys in the context of a pilot program before seeking to resolve these questions in permanent legislation. These issues include, but are not limited to: the actual benefits to be gained by the use of a monkey; the demand by veterans for monkeys; the ability of Helping Hands (the only organization which trains and provides the monkeys at this time) to provide the monkeys in the quantity needed to meet that demand; the effect, if any, that the provision of monkeys should have on aid and attendance allowances; the ability of Helping Hands to train the number of veterans interested in the program to handle the monkeys; the arrangements that need to be made for the care of the monkeys when the veteran is hospitalized; and the best method for handling a situation in which the placement of the monkey did not work out, from either the veteran's or Helping Hands' point of view.

In these times of severe budget constraints, I believe it is also very important to consider the cost-effectiveness of any new benefit. Each monkey is estimated to cost between $11,700 and $21,000 from birth through training to placement. If the assistance provided by a monkey proves enriching to a veteran's life in the manner in which it is anticipated it will, the benefits could be well worth the cost. Before making an open-ended commitment of scarce resources to this innovative program, however, I believe further information is needed.

In January of this year, I learned that funding of the Capuchin monkey program was to end as of March 31, 1989, despite VA's commitment of last July to provide funding until the completion of an evaluation of the benefits of the placement of 10 monkeys with veterans. Believing fundamental fairness to be at issue, and in light of the fact that VA had already invested over $880,000 in the project over the last seven years, I wrote to the Chief Medical Director urging VA to maintain funding for the program at the then-current levels -- $16,600 in research funds per month -- until VA's on-site evaluation and a subsequent determination about the future of the program could be completed. In response, the Committee has received assurances that such funding would continue through the end of June of this year.

I understand that VA's evaluation is about to be completed and I expect its findings will be very positive. I look forward to reviewing this evaluation.

Task Force Recommendations: As I discussed in a statement I made to the Senate on March 23, 1988, (Congressional Record, daily edition, March 22, 1988, page S2904), current law contains a puzzling array of variations among the circumstances in which VA may provide veterans with various types of medical and assistive devices and related services. From my review of those provisions -- including sections 601(6), 612, 614, 617, and 619, of title 38, United States Code -- it has become apparent to me that they have just grown "like Topsy", each provision adding an important piece to the legislative scheme; as a whole, however, the legislative scheme is lacking both clarity and a consistent conceptual basis.

My floor statement pointed to the welter of questions regarding the eligibility criteria for these medical or disability-related items and many troublesome questions about the meaning and relationship of a variety of different terms used in these sections. Moreover, there are many related questions as to how VA has utilized these discretionary authorities, whatever they may mean.

Accordingly, I believe it is necessary to establish a task force to review the law and recommend policies and legislation for the elimination of the inconsistencies. Section 225 of S. 13 would require such a result. Specifically, under this provision, the Secretary would be required to establish such a task force, consisting of eight members of the Department of Veterans Affairs, including representatives of the Veterans Health Services and Research Administration, the Veterans Benefits Administration, and the Office of the General Counsel. At a time to be specified by the Secretary, the task force would submit a report to the Secretary containing a description of the inconsistencies identified, the policies and legislative proposals recommended, and the rationale for each such recommendation. The Secretary would then review the report and either approve the recommendations or prepare alternative suggestions. Within 180 days from the date of enactment, the Secretary would be required to submit the report along with his or her recommendations and an explanation for any differences between the two, to the Senate and House Veterans' Affairs Committees.

Labor-Management Relations: Sections 223 and 224 of S. 13 would address matters concerning labor-management relations involving VA and those VA health-care employees -- principally physicians, dentists, and nurses -- who are employed under VA's title 38 personnel system.

Concerns have been raised by both VA and organizations which represent VA employee groups about employer-labor relations in the wake of the Court's decision in the case Colorado Nurses Association and VA Medical Center, Ft. Lyon, Colorado v. Federal Labor Relations Authority, 851 F.2d 1486 (D.C. Cir. 1988), which was decided in July of 1988. In this case, the U.S. Court of Appeals reversed the prior decision of the Federal Labor Relations Authority, which held that VA has a duty under the Civil Service Reform Act of 1978 (CSRA) to bargain over conditions of employment for title 38 employees. The court ruled that the head of the VA has exclusive discretion to establish regulations concerning the working conditions of those employees appointed under the title 38 personnel system and is, therefore, not under any obligation to bargain with such employees based on the CSRA.

Section 223 of this bill would overrule the Colorado Nurses decision by making chapter 71 of title 5 generally applicable to the Secretary's authority under section 4108 relating to personnel matters. The exception to this would be with respect to the prohibitions set out in paragraphs (1) through (6) of subsection (a) of section 4108, which pertain to potential conflict-of-interest situations arising in the context of the provision of health care.

Concerns also have been raised regarding the fairness and timeliness of the current procedures under section 4110 of title 38, especially in contrast to the system under title 5 which applies to other Federal employees, including other VA employees not covered by the title 38 system.

Section 224 of S. 13 would amend section 4110 of title 38 -- which sets forth procedures to be followed in disciplinary matters relating to title 38 employees -- so as to remove from the coverage of that section disciplinary actions involving lesser proposed penalties which are specified as suspension for 14 days or less, reassignment or reduction in rank without a reduction in basic pay, reprimand, or admonishment. All other disciplinary actions would remain covered by the current section 4110 process.

This provision recognizes the changes in labor-management relations since 1946, when the current law provisions were enacted. While following the basic construct of title 5 grievance procedures, this section also would protect and preserve the uniqueness of the title 38 system where it is most necessary -- where the quality of care may be at issue.

The need for these provisions is essentially twofold -- to ensure that title 38 employees are afforded the same fundamental rights as other government employees in terms of their employee-management relations, while protecting the special professional nature of title 38 employees, and to provide VA with an important tool in its ongoing efforts to recruit and retain qualified health-care personnel.

S. 900: The purpose of respite care is to provide relief for the caretakers of chronically ill individuals who, without the caretakers' services, would likely be institutionalized. Providing care for such a patient at home instead of in an institution is often, many experts contend, better for the patient's overall health and more cost-effective than institutional care. Providing the patients with intermittent scheduled stays at VA medical centers gives the caretakers some breaks from their demanding work.

S. 900, introduced by Senator Rockefeller and myself, would extend for one year, through FY 1990, VA's authority to furnish respite care to certain chronically ill veterans and to extend to February 1, 1990, the date by which the Secretary of VA is to submit a report on the evaluation of the program to the Senate and House Veterans' Affairs Committees. The VA's bill, S. 748, would extend the program authority for two years.

On April 30, 1986, I introduced S. 2388, which included a provision authorizing VA to furnish respite care. A provision derived from that measure and also derived from a provision introduced by the then-Chairman of the Veterans' Affairs Committee, Senator Murkowski, was enacted in section 210 of Public Law 99-576. Current law authorizes VA to furnish respite care services until September 30, 1989, and requires the Secretary to conduct an evaluation of the efficacy and cost-effectiveness of the program and report the results of the evaluation to the Veterans' Affairs Committees by February 1, 1989.

S. 947: This measure, the proposed "Veterans Health-Care Personnel Act of 1989", is intended to provide VA the necessary tools, strategies, and flexibility to attract qualified and competent health-care personnel -- registered nurses, pharmacists, physical and occupational therapists, and others -- in today's competitive marketplace. It is cosponsored by Senators Mitchell, Matsunaga, DeConcini, Rockefeller, Graham, Inouye, Kohl, Pell, Wirth, and Kerry. Reflecting my very strong concern that we must find ways to reduce the Federal deficit, this legislation seeks to find methods to improve VA programs without incurring major new costs.

Both within and outside of VA, the problem of recruiting and retaining sufficient numbers of qualified health-care personnel is one which has intensified in recent years. A number of factors have contributed to this problem, including inadequate salaries, increased demand for personnel, poor working conditions, and decreased enrollment in educational institutions which prepare health-care professionals. Because the health care furnished to veteran-patients is largely a function of the quality of the personnel furnishing the care, we must do all that we can to enable VA to attract the "best and brightest" health-care personnel into the system. These men and women who give so much of themselves as they fulfill their daily responsibilities also require respect and support. I believe it is our job to ensure that they receive that respect and support both because it is right and because it will lead to better health care for veterans who need their attention.

S. 947 would provide VA the authority to be proactive in its recruitment and retention efforts rather than merely reactive. It is designed to avoid counterproductive lag times. If the VA had the ability to keep pace with rates paid in the community, I believe that greater numbers of health-care professionals would seek out VA as an employer and the expensive and demoralizing turnover would be significantly decreased.

Competitive Pay: Although special salary rates have helped VA maintain a competitive posture within an individual health-care facility's respective labor market area, this authority was conceived as a measure which might be used in special circumstances rather than as the norm. At the time this authority was first enacted, we did not anticipate that VA salaries would lag behind to such a great extent or that salaries in a community would change so frequently. Turnover also adds significant costs to the already expensive proposition of furnishing health care. For each new employee hired there are costs associated with advertising, interviewing, processing of paperwork, and orientation.

To reverse this trend and to provide VA the tools to respond quickly to community conditions, section 101 of S. 947 would require the VA Secretary to establish and maintain levels of competitive pay for full- and part-time RNs, registered nurse anesthetists, and certified registered nurse anesthetists, and authorize the Secretary to establish and maintain levels of competitive pay for other health-care employees covered by title 38 for pay purposes only -- the so-called "hybrids". These pay rates would be competitive with but would not exceed the pay of employers offering similar employment and competing in the same labor market area for qualified employees. Although this sounds very similar to the description for special salary rates, the major differences between competitive pay and the existing statutory authority for special rates include the following: (1) special rates are discretionary while competitive pay for RNs, RNAs, and CRNAs would be mandatory, (2) competitive pay salary ranges would generally be determined by the individual facility director while special rates are approved by VACO, (3) competitive pay calls for salary ranges to be increased or decreased on an annual basis depending upon labor market area rates, and (4) in the instance of competitive pay, a pre-established time would be established for review and adjustment of pay grades rather than waiting for a serious problem to arise and begin to fester, as is the case with the current system of relying on special rates. Of course, in the intervening year between routine competitive pay reviews and adjustments, special rates could still be implemented as needed.

This measure would require directors of each VA health-care facility to perform an annual survey, no later than June 1, 1990 -- and on December 1, 1990, and on each December 1 thereafter -- of basic entry wages paid in comparable facilities within their labor market areas -- the areas which the directors identify as where their competitors are located -- and then to establish or adjust competitive pay rates. Not all facilities within a labor market area are necessarily competitors of VA health-care facilities. Facility directors would be given maximum flexibility to define the labor market area with which they are competing. S. 947 calls for determining entry-level salaries and then building grades and steps based on those entry-level rates. To avoid salary compression within a grade or between grades, this measure would require that the rates of pay for grades and steps established maintain the same proportional distribution between the rates of steps and grades that currently exists. To maintain consistency within the pay system, this bill would require the CMD to prescribe the number of grades (but not less than three) and the number of steps within each grade. If a new grade or additional steps within a grade are added by the CMD, the new grade or step would be required to bear the same proportionate relationship to other grades or steps as current grades or steps bear to one another.

This measure, as does the title 38 provision authorizing special rates, would require that the wage rates paid be competitive with the wage rate paid in the labor market surveyed but not exceed the highest such rate. This provision reflects my belief that the Federal government should not be the wage leader in a given community and contribute to the inflationary spiral in medical care costs. This philosophy is not intended to suggest that Federal employees are not of top quality but rather reflects my view of the special responsibility of the Federal Government not to generate inflated pressures.

In addition, this measure would cap entry-level salaries of grades established primarily for supervisors and managers at the statutory cap of the Executive Schedule, currently $75,500, and it would cap the entry-level salary of all other grades at the level of step 10 of grade 13 of the general schedule published by the Office of Personnel Management, currently $53,460.

Under S. 947, salary ranges may also be adjusted downward. Thus, in areas where the VA is the salary leader by virtue of the Federal pay scale being higher than that within the community, VA would be required to adjust that salary scale downward. I'd like to stress that the current wages of employees would not be affected by that adjustment -- basic salary rates of individuals already on board would be protected and would remain the same until the community caught up with the Federal rate. However, the concept of competitive pay would be an inequitable one if it called only for increased salary rates to meet local standards and excluded decreases to reflect those same standards.

In a similar light, employees transferring from one health-care facility to another would retain their same step and grade if they retained the same position with similar responsibilities at the second facility, but their earnings would reflect the specific salary attributed to that step and grade at the new facility. Hence, their salaries could increase or decrease. The concept behind competitive pay is that salaries should reflect the wages of the community in which the VA health-care facility is located.

Overtime Payments to Registered Nurses: Section 102 of this measure would require VA to pay overtime to RNs, RNAs, and CRNAs at the rate of one and one-half times such nurse's hourly rate of basic pay. Current law limits overtime pay for these employees to a rate not to exceed one and one-half times the hourly rate of basic pay for the minimum rate of Intermediate grade of the Nurse Schedule, currently $13.87 per hour. As of December 31, 1988, of the 36,305 full-time, part-time and intermittent RNs working for VA -- 514 of whom are RNAs or CRNAs -- 23,934 (66 percent) are at the Intermediate grade or higher.

The provision in current law was enacted in 1973 as part of Public Law 93-82, and was intended to be similar to the method used for computing overtime payments for General Schedule and Wage Board employees pursuant to title 5. That title 5 provision has remained unchanged. However, VA is competing with non-Federal hospitals for scarce RNs, and those hospitals routinely pay one and one-half times a nurse's actual hourly rate of basic pay for overtime hours worked. This places VA at a severe disadvantage.

Head Nurse Pay Differential: Unlike most hospitals, VA pays RNs based on their credentials and performance rather than on the position they hold. Because a nurse working at the bedside can earn as much as a head nurse without assuming these additional administrative responsibilities and management "headaches", there is no financial incentive to assume that management role. The impact of this is illustrated in a recent survey of 172 VA medical centers which identified a growing vacancy rate for head nurses -- 18.5 percent in fiscal year 1986, 22.9 percent in fiscal year 1987, and 22.4 percent in fiscal year 1988.

I believe that the head nurse position is a pivotal one if good quality patient care is to be provided to our Nation's veterans. Therefore, section 103 of this bill includes a provision to provide a 6-percent pay differential to nurses appointed to the head nurse position. This amount is based on the VA policy of providing a two-step increase in the case of a promotion. Two steps is approximately equivalent to 6 percent. In recognition of those nurses assigned to that position on an interim basis, S. 947 provides that those assuming that role for a period in excess of 30 days also would receive the 6-percent differential.

RN Professional Specialty Recertification: Section 106 of S. 947 would require the Secretary to award each nurse upon recertification in a professional specialty a lump-sum payment in an amount equal to one percent of the nurse's basic annual rate of pay provided that the nurse's last performance evaluation was not less than satisfactory. The recertification would be required to be issued by a recognized professional organization and in the specialty in which the nurse is employed by VA.

Certification, unlike licensure, is not a requirement for nursing practice. It is a credential which is pursued by those professionals who strive for excellence and recognition in their field. To become certified a nurse must take a difficult written examination which tests knowledge and the ability to apply that knowledge in a certain subject area. To become recertified, nurses generally must prove -- every two to four years depending upon the specialty area -- that they have continued to practice in their specialty area, attended continuing education programs, and, in several instances, shared their knowledge with others through teaching. Currently, VA nurses in Senior grade or below may receive a one- to five-step increase on the basis of professional achievement provided they have demonstrated excellence in performance and have a potential for assuming greater responsibility. One way this achievement can be demonstrated is by becoming certified by an appropriate national certifying body. It is my understanding that most VA nurses receive at least a one-step -- 3.3-percent -- increase upon certification. However, no economic incentive is provided for recertification.

I want to make sure that a special effort is made to encourage and retain those nurses who have taken the time and made the effort to take this additional step to demonstrate a higher level of knowledge.

Exemplary Performance Cash Rewards: Section 201 would authorize the Secretary to make cash awards of no less than 5 percent and no more than 20 percent for exemplary performance to no more than 20 percent of supervisors and managers in each of the professions listed in section 4104(1) of title 38 -- so-called "title 38" employees, i.e., physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded-function dental auxiliaries. I believe such a provision is long overdue.

Currently two provisions in title 5 provide for cash awards for superior performance, section 5384 and section 5406. Pursuant to section 5384, performance awards may be made to employees within the Senior Executive Service to encourage excellence in performance. The amount of the award may not be less than 5 percent nor more than 20 percent of the appointee's rate of basic pay. In VA, those eligible for such awards include facility directors, regional directors, and key leadership persons in VA Central Office.

Section 5406 of title 5 requires the payment of performance management recognition awards for any supervisor or management official in General Schedule grades 13, 14, or 15 who receives an outstanding rating during the performance review process. The amount of the award is limited to not less than 2 percent and not more than 10 percent of the employee's annual rate of basic pay. Those VHS&RA employees eligible for these cash awards include only the directors of clinical and non-clinical services -- that is, those professionals other than nurses, physicians, dentists, and other title 38 employees listed in section 4104(1) of title 38.

I believe that all title 38 managers and supervisors should be eligible for cash awards which recognize their significant contribution to the furnishing of good quality patient care. Under S. 947, awards would be granted to title 38 employees for their exemplary performance according to criteria established by the Secretary. In order to address the criticism of the title 5 program that many of those who receive the awards are not outstanding, I intend to recommend strongly that, if this provision is enacted, the Secretary carefully monitor the recipients to be certain that the awards are distributed in an equitable fashion only to employees who provide truly exemplary performance.

Dependent Care Assistance Program: In response to a suggestion received from a VA physician who is a California constituent of mine, section 202 of this legislation would require the Secretary to establish and operate for VHS&RA employees a dependent care assistance program which meets the requirements of section 129 of title 26 which permit employees to contribute up to $5,000 annually tax free ($2,500 in the case of a separate return by a married individual) for the care of the employee's dependents. Under such a program, upon the request of the employee, an employer excludes from the employee's gross income specified amounts which would be placed in an escrow account. The employee then draws upon this account for dependent care costs. Just as amounts for 401(k) plans are treated for Federal income tax purposes, the amount so set aside is not reported to the Internal Revenue Service as part of the employee's earned wages, thus resulting in a reduction of the employee's income tax.

On March 19, 1987, my constituent, Dr. David L. McArthur, a physician at the Long Beach VA Medical Center, submitted this suggestion through the VA Incentive Awards Program. This suggestion was referred to the VA General Counsel who sought guidance from OPM. In an October 5, 1988, memorandum from the VA General Counsel to the Director of the Office of Personnel and Labor Relations, the General Counsel advised that OPM stated that there was nothing under any title 5 provision permitting a Federal agency to establish such a program, and VA General Counsel indicated that VA did not have sufficient authority to establish such a program for title 38 employees.

The growing crisis in recruitment and retention of health-care personnel poses a threat to VA's capability of providing health care to our Nation's veterans. I believe it is imperative that VA begin to examine a wide range of employee benefits which may assist in resolving some of these problems, one of which is certainly assistance in the area of dependent care programs -- an area of long-standing, continuing, and keen interest on my part.

Waiver of Retirement or Retainer Pay for VA Health-Care Professionals: Section 104 of this measure would authorize the Secretary -- in the case of a shortage of scarce health-care professionals providing patient care services or services incident to direct patient care -- to make an exception to the title 5 provision reducing the amount of retirement or retainer pay of a retired member of the uniformed services employed by the Federal government. The Secretary would be authorized to exercise this authority, if necessary, to meet special or emergency VA employment needs which result from a severe shortage of well-qualified candidates. This provision would expand the current authority in section 4107(i) of title 38, relating to physician appointments, which was enacted in 1984 in Public Law 98-528. On April 12, 1989, while testifying before the House Committee on Veterans' Affairs Subcommittee on Hospitals and Health Care, Dr. Gronvall, VA's Chief Medical Director, stated that VA recommended expansion of this new authority to cover all VA occupations (not only nurses) providing patient care services or services incident to direct patient care.

Senator Murkowski's bill, S. 574, proposes such an expansion for registered nurses. A draft bill transmitted by VA on May 10, which I introduced as S. 1004 on May 16, proposes an expansion similar to section 104 of S. 947.

The number of scarce health-care professionals retired from the Armed Forces is difficult to determine, and the number of those who would want to continue their careers within the Federal government is equally difficult to ascertain. However, it has been suggested that for those Armed Services personnel who do wish to continue their careers outside the uniformed service, VHS&RA would be a natural environment in which they might work. According to VA, the currently-authorized physician program has been exercised infrequently and prudently, but it has been helpful in recruiting qualified physicians in a variety of special shortage situations. If other retired Armed Services health-care professionals could be enticed to work within VA in scarce positions, the cost associated with vacant positions might decrease.

Special Salary Rates for Health-Care Employees: Although the implementation of competitive pay would greatly reduce VA's need for special salary rates, that need would not be eliminated totally. In today's fast-paced recruitment marketplace, wages for RNs might move ahead rapidly in the middle of the year, making an additional adjustment necessary, or, for those employee categories for which competitive pay is authorized but not required, the continuation of special rates as currently implemented would certainly be necessary if competitive pay is not implemented for them. Thus, it is important to ensure that the mechanism under which special rates are paid is maintained and improved as necessary.

The extent to which salary rates can be increased under the current authority is limited to the amount by which the maximum for the affected grade exceeds the minimum for that grade. Section 105(A) of this measure would raise this limit so that the increase could be up to twice the difference between the maximum and the minimum for the grade involved and would require the Secretary to notify the Committee when such an increase is 94 or more percent of the maximum amount permitted. This provision is identical to section 622(a) of the provisions of S. 2011 as passed by the Senate on October 18, 1989.

Approval of Special Rates of Pay: Section 105(B) would (a) reduce, from 90 to 45 days, the period, after VA submission of a title 5 health-care employees' special-pay rate request, in which the President or his agent may disapprove the proposed rate, and (b) clarify that the proposed rate may be put into effect immediately upon approval given in a shorter period. This provision is identical to section 622 of the provisions of S. 2011 as passed by the Senate on October 18, 1988. VA's Chief Medical Director testified in support of this provision at last year's hearing on June 16, 1988.

Under current law, when the Secretary determines it to be necessary in order to obtain or retain the services of certain personnel employed under the title 5 personnel system who provide direct patient-care services or services incident to direct patient care, the Secretary may increase the rates of basic pay authorized under applicable statutes and regulations. In such cases, the Secretary is required to notify the President not less than 90 days prior to the effective date of the proposed increase. The President then has that 90-day period to disapprove the proposed increase and, if so doing, the President must notify the appropriate Committees of the Congress of the reasons for such action.

Requests to establish special pay rates are initiated at VA Medical Centers and are submitted to the VA Central Office (VACO). Once submitted to VACO, the justification for the special rates is carefully reviewed and either approved, returned for further information, or disapproved. If approved by VACO, the request is then sent on for review by the President's agent, the Director of the Office of Personnel Management (OPM). The elapsed time to this point can average as long as 90 days. A review conducted by the Director of the VA's Office of

Personnel and Labor Relations at the Committee's request showed that between August 1, 1988, and January 31, 1989, 51 special-rate authorizations were subject to review by OPM. Of these 51 cases, the average turnaround time was 49 days. OPM has never disapproved a special-rate authorization proposed by the VA under section 4107(g).

I am concerned that the lengthy pre-approval process -- during which time the VA facility is already experiencing a staffing shortage -- may serve to worsen the staffing problem. Staff may become overworked and frustrated and thus seek to leave the organization. This, of course, creates an even greater shortage and may cause the care furnished veterans to suffer. This provision is identical to an S. 2011 provision which was passed by the Senate last year but was not included in the legislation finally enacted because of other, unrelated matters.

Appointment of Veterans' Administration-Trained Personnel: As part of the VA's mission to establish and implement education and training programs for health-care disciplines, VA health-care facilities provided training opportunities for tens of thousands of students each year -- close to 100,000 students in 1987. At the time of graduation, many of these students turn to the VA as a potential employer. Persons in those professions who are not covered under the VA's title 38 appointment authority -- generally, health-care personnel other than registered nurses, physicians, and dentists -- are required to complete the time-consuming process of examinations and register listings prescribed for the Civil Service competitive system. This process justifiably focuses on the preservation of merit principles for filling vacancies rather than on the need to appoint much-needed health-care personnel in an expedited fashion. Unfortunately, this often results in graduates, whom VA would like to employ, seeking and accepting employment elsewhere.

Section 401 of this measure would authorize the Administrator to appoint, without regard to the Civil Service examination and register processes, those who, in the previous year, have graduated with a recognized degree or certificate from an accredited institution in a health-care profession or occupation, and who received their clinical training at VA facilities to positions at those facilities. This provision is similar to section 621 of the provisions of S. 2011. Rather than describing as one year the length of time within which such an appointment would be made, S. 2011 used the term "recent graduate". I believe that greater specificity should help avoid any confusion as to the intent of this provision. Although the S. 2011 provision was passed by the Senate last year, it was not included in the legislation finally enacted because of other, unrelated matters.

In proposing this new authority, I do not intend that principles of the merit process -- or of veterans' preference -- be ignored, nor do I intend that other screening procedures to ensure the hiring of high quality personnel be bypassed. However, because these graduates have completed a course of education with a practicum at a VA health-care facility, supervisory personnel at the VA will have had an opportunity to assess and evaluate their work in a clinical setting, and thus can be expected to know far more about such applicants' clinical competencies than they do about other applicants.

Assistance to Health-Personnel Education Institutions: Section 302 of this measure, which is virtually identical to section 624 of S. 2011, would: First, authorize the appropriation of $5 million for each of fiscal years 1990 and 1991 and $6 million for each of fiscal years 1992 and 1993 for the VA to provide assistance in the education of allied health-care personnel, other than physicians and dentists, at VA-affiliated schools and to assist in developing and evaluating new health careers, interdisciplinary approaches, and career-advancement opportunities. This provision is identical to section 624 of S. 2011, a provision which was passed by the Senate last year but was not included in the legislation finally enacted because of another, unrelated matter.

Second, require that the development of those careers, approaches, and opportunities described above must occur in collaboration with representatives of the professions the members of which are currently responsible for carrying out the duties involved.

Third, authorize the VA to expend up to 10 percent of each year's appropriation on VA programs designed to develop or initiate improved methods of education and training for health-care personnel.

Serious shortages continue to exist in many categories of health-care personnel, and the numbers being trained are not sufficient. Experts are predicting that this trend will continue. I believe that, if VA is to have sufficient numbers of qualified health-care professionals, it must be prepared to provide some funding to schools which are committed to VA and which will expose their students to the high quality of care furnished there.

It is my intent that, in the case of each grant award, VA obligate in any fiscal year only such funds as the school requires for that year rather than obligating in the fiscal year in which the project is approved the total sum required by the school for the life of the project. Although I am sympathetic to the need of schools to be assured of full funding throughout the expected life of the grant, I would like to see as many programs as possible be implemented so as to address more quickly VA's critical health personnel shortage.

Health-Professional Scholarship Awards: Section 301, which is identical to section 623 of the Senate-passed provisions of S. 2011, would require the Secretary to ensure an equitable allocation of scholarships to persons enrolled in their second year of a program leading to an associate degree in nursing.

I am very concerned about the continuing shortage of nursing personnel and believe that all efforts should be made to recruit such personnel expeditiously. While strongly supporting baccalaureate education for nurses and other health-care professionals, particularly in today's complex health-care environment and, thus, believing that priority should be given to those working on completion of a baccalaureate degree, I am concerned that some communities do not have readily accessible 4-year programs. Persons in such locales who are interested in nursing as a career and are unable to attend school without some financial support are therefore currently being precluded by VA's practice from obtaining such VA assistance. Section 301 would remedy this situation. This provision is identical to section 623 of S. 2011, a provision which was passed by the Senate last year but was not included in the legislation finally enacted because of another, unrelated matter.

Pilot Program on Pay and Personnel Management Practices: Section 402 of this measure, which is similar to section 625 of the Senate-passed provisions of S. 2011, which is similar to section 332 of S. 9, a provision reported by the Committee and passed by the Senate on December 4, 1987, would (1) require VA during calendar years 1990, 1991, and 1992 to conduct a pilot program at not less than five VA medical facilities to determine the desirability of (a) establishing programs which foster interdisciplinary professional collaboration and collegial relationships between physicians and RNs, (b) creating new alternatives for utilizing the skills and knowledge of RNs in furnishing direct-patient care, (c) increasing the pay differential for evening and night service, (d) revising the grade, classification, pay, and performance qualifications and other appropriate personnel management systems used in VHS&RA, and (e) establishing flexible employment benefits programs for VHS&RA employees; and (2) require periodic reports on the pilot program by the CMD to both Committees on Veterans' Affairs, followed not later than 60 days thereafter by the Secretary's comments on each such report.

A detailed history of matters leading up to the introduction of this provision can be found in the Committee report accompanying S. 9 (S. Rept. No. 100-215, pages 159-161) and in the Committee report accompanying S. 2011 (S. Rept. No. 100-439, pages 158-163). Unfortunately, the pilot program was not agreed to by the House conferees, but, rather, a provision requiring the Administrator to study and report on the possible effects of pay compression, increased pay differentials for evening- and night-tours of duty, and flexible benefits programs within VA medical centers was enacted on May 20, 1988, as section 231 of Public Law 100-322. That report is due to be submitted to Congress on May 19, 1989. Because I remain convinced that such a pilot program is the best way to study and consider such alternatives, I am proposing it again as part of this bill.

Leave Sharing: Public Law 100-566, the Federal Employees Leave Sharing Act of 1988, enacted on October 31, 1988, provides for a five-year leave-sharing program for title 5 employees. This authority, subchapter III of chapter 63 of title 5, requires OPM to establish a program under which annual leave accrued or accumulated by an employee may be transferred to the annual leave account of any other employee for the purpose of assisting the receiving employee during a time of medical emergency. Subchapter IV of chapter 63 requires OPM to establish during that 5-year period a leave "bank" demonstration project under which employees may voluntarily transfer annual leave to a leave bank from which annual leave may be made available to an employee needing such leave because of a medical emergency Although earlier laws authorized testing such programs for title 38 employees, these provisions expire on September 30, 1989. Section 203 of S. 947 would require the Secretary to establish, or enter into an agreement with OPM to participate in, a leave-transfer program for health-care professionals such as that described in title 5 and provide the Secretary the authority to establish, or enter into an agreement with OPM to participate in, leave banks for health-care employees.

VA has submitted draft legislation having a similar purpose, and I introduced that as S. 899 on Tuesday, May 2, at the Administration's request.

Conclusion

There are obviously a great number of bills to be discussed today that are designed to improve the health care furnished to our Nation's veterans. The members of our Committee are very interested in the ideas and views of those appearing before us today as well as those who have submitted written testimony. I again want to thank all the witnesses for their participation and help on these important matters.

STATEMENT OF SENATOR FRANK H. MURKOWSKI (R-AK)
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS HEARING
MAY 18, 1989

GOOD MORNING, MR. CHAIRMAN. FIRST, I WOULD LIKE TO EXTEND A WARM WELCOME TO THE WITNESSES SCHEDULED TO TESTIFY THIS MORNING. WE THANK YOU FOR YOUR PARTICIPATION AND LOOK FORWARD TO LEARNING YOUR VIEWS.

WE WILL HEAR TESTIMONY TODAY ON A WIDE RANGE OF ISSUES RELATING TO VETERANS' HEALTH CARE. I AM PLEASED THAT THE COMMITTEE IS SCHEDULED TO HEAR TESTIMONY ON TWO BILLS WHICH I INTRODUCED, TOGETHER WITH SENATORS SIMPSON AND JEFFORDS. S. 573 RELATES TO THIRD PARTY REIMBURSEMENT, AND S. 574 CONTAINS VARIOUS PROVISIONS SOME OF WHICH PROVIDE VA WITH THE AUTHORITY TO FURNISH INNOVATIVE AND NEEDED SERVICES TO OUR MOST SEVERELY DISABLED SERVICE-CONNECTED VETERANS.

DURING MY REVIEW OF THE WRITTEN TESTIMONY TO BE PRESENTED TODAY, I NOTED THAT MANY -- IF NOT ALL -- OF THE VETERANS' SERVICE ORGANIZATIONS OPPOSED MY LEGISLATION TO EXPAND VA'S THIRD PARTY REIMBURSEMENT AUTHORITY. VA SUPPORTS IT AND PROPOSES THAT THE DEPARTMENT RETAIN 50 PERCENT OF THE MONEY COLLECTED UNDER THIS PROGRAM. I AM ANXIOUS TO DISCUSS S. 573 WITH THE REPRESENTATIVES OF THE VETERANS' SERVICE ORGANIZATIONS. I AM ALSO INTERESTED IN

VA's proposal and look forward to discussing it with my good friend Tony Principi.

I am somewhat disappointed by VA's comments regarding my proposals on noninstitutional care and assistive animals. These programs are, of course, targeted toward certain service-connected veterans. In my view, they are VA's highest priority and in that light deserve special attention and programs.

I look forward to hearing the testimony of the nursing organizations who will be testifying on the critical issues of recruitment and retention of nurses. One can rarely pick up a newspaper or watch television news without learning of this very serious problem. This Committee has been responsive to it and has undertaken efforts to improve VA's ability to recruit and retain nurses by reporting legislation -- which was ultimately enacted into Public Law 100-322 -- to provide monetary as well as educational benefits to VA nurses. We went down the right path, but clearly much more needs to be done. I don't know if the approach taken in the Chairman's bill (S. 947) is the appropriate one. I am keeping an open mind and hope to learn more about that legislation during today's hearing.

Again, I thank you all for your attendance. Thank you, Mr. Chairman.

STATEMENT OF
ANTHONY J. PRINCIPI
DEPUTY SECRETARY
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
MAY 18, 1989

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the array of legislative initiatives on your agenda today, including certain VA proposals which we appreciate your introducing on behalf of the Administration. We have noted that with respect to several subject areas, the committee is considering different bills addressing the same subject. Accordingly, we have organzied this statement by subject matter.

Before I begin, I would note that the Department of Justice is now studying the various bills that are the subject of the Committee's hearing, and has a number of constitutional and other legal concerns regarding those measures. The Justice Department intends to prepare a separate letter to the Committee discussing those concerns.

STATE HOME GRANT PROGRAM EXTENSION

Both section 213 of S. 13, and section 4 of S. 748, would authorize appropriations for the State home grant program. The former would continue the program for three years, while the latter would authorize appropriations for five years. The State home grant program provides support to States to assist in the construction or acquisition of State home facilities for veterans. Over the years, these grants have created a network of 58 State veterans facilities in 36 States, which make it possible to provide medical care to many more veterans than can receive care in VA facilities. It is a cost-effective program in which Federal participation is limited to no more than 65 percent of the cost of any one project. We support continuation of this valuable program, and urge your adoption of the five year extension contained in S. 748, our legislative proposal.

RESPITE CARE PROGRAM EXTENSION

S. 900 would extend for one year from September 30, 1989, to September 30, 1990, authority for VA's respite care program. Section 6 of S. 574, and section 3 of S. 748, would also extend the respite care program, but for two years until September 30, 1991. Finally, both S. 900 and section 6 of S. 574 would would extend for one year, the date by which a report on an evaluation of the program must be submitted to the Congress.

Our respite care authority allows us to provide chronically ill veterans who reside at home with brief, planned periods of care in VA facilities in order to provide members of the veterans' families with some relief from the physical and emotional rigors of continuous home care. Our experience with the program, which allows veterans to remain at home in the care of their loved ones, and avoid costly and protracted periods of institutional care, appears to be working very well. We support its extension, and urge that you adopt section 3 of S. 748, our proposal for a two-year extension.

SHARING SPECIALIZED MEDICAL RESOURCES

Section 222 of S. 13 would expand our authority to "share" specialized medical resources" with certain community providers. The proposed changes would enable VA outpatient clinics to enter into such sharing agreements, and our health-care facilities would be authorized to enter into sharing agreements with such institutions as research centers and nursing homes. The measure would also delete a provision limiting sharing to the same "medical community", a term which is not defined in existing law. The bill would provide greater flexibility to VA facility directors in setting prices for resources provided, and finally, it would make clear that all reimbursements to VA must be allotted to the VA facility that furnished the resources.

These changes are likely to result in better utilization of specialized medical resources. We favor the enactment of the provision. If enacted, it would not result in any new costs to VA.

ASSISTIVE ANIMALS

Mr. Chairman, three legislative proposals are before you today which would authorize VA to provide certain animals to disabled veterans. Section 214 of S.13 would require VA to establish pilot programs for furnishing assistive monkeys and assistive dogs to quadriplegic veterans. In a similar but broader provision, section 4 of S. 574 would authorize VA to provide simian aides and assistive dogs to all veterans entitled to disability compensation for quadriplegia. Finally, section 215 of S. 13 would require VA to establish a pilot progam for furnishing signal dogs to hearing-impaired veterans.

We have long provided financial support for research which has sought to demonstrate that trained monkeys may assist spinal cord injured persons in carrying out certain tasks. We are nearing conclusion of an evaluation of the research project of M. J. Willard, Ed.D., a project we have helped fund for some time, to determine its potential benefit for veteran patients. Until that determination is made, however, we don't believe it would be appropriate to endorse either of the provisions regarding simian aides.

We also object to the proposals which would authorize VA to furnish veterans with specially trained dogs. Trained dogs would be of limited use to quadriplegic veterans because of the patients' severe limitations and the limited capacities of the animal. Most quadriplegic veterans would not be able to attach the dog to a wheelchair to pull it, or receive objects retrieved by the dog.

Finally, we do not support the pilot program to furnish hearing-impaired veterans with signal dogs which are useful to profoundly deaf veterans only in rare circumstances. Signal dogs are specially trained to attract the attention of deaf individuals. They are rarely used because many mechanical and electrical devices are available for the same purpose, e.g., flashing lights on phones and doorbells, fans and bright lights on alarm clocks, hearing aids, and other electrical amplification signaling devices.

PROCREATIVE SERVICES

Mr. Chairman, section 211 of S. 13 would authorize VA to furnish service-connected veterans and their spouses with certain procreative services to help them overcome the effects of service-connected disabilities which prevent or impair their ability to conceive a child. Both provisions preclude furnishing services involving use of a surrogate mother, or the sperm or egg cells of anyone other than the veteran or the veteran's spouse. We do not support enactment of these provisions.

As you know, we have in the past withheld our support from similar legislative proposals because we view them as placing VA in the position of regulating access to reproductive technology when there is no societal consensus on the propriety of such a governmental role. That position has resulted from our inability to adequately answer many very difficult and troublesome questions regarding the furnishing of such services. To cite but a few examples, the legislation raises such issues as how the Department should respond to requests for services from couples likely to produce a severely retarded child, or who have a history of abusive behavior, or who have a severe psychiatric disability. Similarly the legislation leaves unanswered questions regarding the number of times VA should provide services if the eligible couple fails to conceive, and whether services should be provided to help the couple conceive a second or third or more times. Although we are certainly supportive of making efficacious medical technology available to veterans, we cannot escape the fact that authorizing procreative services represents more than simply providing a new service to veterans. Absent some consensus on these matters, we cannot support enactment of these provisions.

SOUTH CAROLINA RESEARCH CENTER

S. 165 would direct the VA to construct and appropriately equip a medical research center on land provided by the Medical University of South Carolina in Charleston, South Carolina. However, the construction could be carried out only if the VA and the University enter into an agreement to split the construction and equipment costs of the facility.

The current VA 5-year facility plan for the VAMC Charleston calls for a $1.8 million minor construction project to correct research space deficiencies. The bill would direct construction of a research center without regard to existing national planning processes for such projects, processes aimed at assuring equitable distribution of VA health-care resources in relation to veterans' needs throughout the country. Enactment of such legislation would undermine the orderly system of planning which VA employs, a planning process which we believe yields the best and most equitable results in the long run. Thus, we oppose enactment of this measure.

We also note that although the bill provides that VA and the University may agree to joint ownership, management, and use of the medical research center, we are not aware that VA has ever participated in an arrangement involving joint ownership of a facility. This untested arrangement would involve not simply harmonizing VA's statutory responsibilities with that of its "partner," but anticipating and making provision for the many issues, not necessarily foreseeable, likely to arise in the management and use of that facility.

If VA were required to construct a medical research center in Charleston, South Carolina, and the University agreed to pay half the cost, VA's share of the one-time costs would be about $9.7 million. This estimate includes $2 million for equipment, $50 thousand for furnishings, and $7.6 million for construction. Operating costs would approximate $232 thousand per year.

NONINSTITUTIONAL ALTERNATIVE TO NURSING HOME CARE

Section 7 of S. 574 would add a new section to title 38, to authorize VA to furnish some service-connected veterans with noninstitutional services on a contract basis as an alternative to nursing home care. Veterans eligible for services would be those receiving, or needing nursing home care primarily for treatment of their service-connected disability. The proposal would require us to furnish the patients with case managment services, and to evaluate the program and report findings and conclusions to the Congress by September 30, 1992.

We do not support enactment of this proposal, which would change the VA's medical mission to one that involves the provision, or simply reimbursement, of nonmedical social support services such as homemaker, chore and personal care services. Over the years, we have repeatedly objected to legislative proposals which would have called for VA to furnish nonmedical support services. While we support noninstitutional health services programs, such as hospital based home care and adult day health care, we have long relied on community resources to provide nonmedical health-related services. Moreover, the types of support services this measure would authorize--homemaker services and personal care services such as assistance with feeding, washing, and dressing--duplicate, in many respects, the assistance for which basic aid and attendance allowances are currently paid to many veterans. Finally, use of health related social services as a substitute for nursing home care has been studied extensively. The services have been found to improve the client's quality of life, but they are not always a substitute for nursing home care.

We estimate that enactment of a pilot program at ten VA medical centers would cost approximately $13.6 million in Fiscal Year 1990, and $68 million over five fiscal years.

REPEAL OF AUTHORITY TO FURNISH TOBACCO

Section 5 of S. 574 would repeal section 615 of title 38, which authorizes the Secretary to furnish tobacco to veterans receiving hospital or domiciliary care. That section of law has been in existence for many many years, and predates widespread awareness of the health hazards of smoking. We strongly urge repeal of the section which we do not now use and have not used for many years. In our view, repeal would be symbolic even though it would have no cost impact.

DENTAL

Section 2 of S. 748, a VA legislative proposal you introduced on behalf of the Administration, would revise VA's authority to furnish outpatient dental care. Current law authorizes VA to provide medical services needed to prepare for a patient's hospital admission, but by virtue of a statutory limitation on the provision of outpatient dental care precludes VA from furnishing medically-required pre-admission dental procedures. Thus, existing law would require costly VA hospitalization to permit the performance of medically-needed but limited dental work in preparation for a veteran's hospitalization in cases where dental infection, for example, could jeopardize a patient's well-being. The provision would enable VA to provide limited outpatient dental services in preparation for such procedures as cardiac valve replacement, implantation of hip and knee prostheses, and radiotherapy. Enactment of this provision would reduce the period of hospitalization for such patients avoiding costs we estimate to be some $520,000 for each of the next five fiscal years.

Section 2 of S. 748 also includes a cost-savings amendment which would require us to obtain a second opinion in instances where the cost of proposed dental care for a veteran by a fee-basis practitioner would exceed $1000. Current law requires a second opinion for procedures over $500. In keeping with the rising cost of medical and dental care, this provision would provide for a $1000 ceiling and a periodic adjustment of the limit. By avoiding costly reexaminations, it is anticipated that the proposal would result in a cost savings of approximately $198,000 annually for each of the next five fiscal years.

VETERANS BENEFITS LAWS INCONSISTENCIES

Section 225 of S. 13 would require us to establish a task force to identify inconsistencies and make recommendations for legislation concerning our authorities to provide prosthetic services. These authorities have been added and modified over the years as Congress expanded veterans' eligibility for health care benefits. The changes were made incrementally so that some degree of inconsistency and duplication exists. The proposed task force would be required to submit a report to the Secretary identifying these inconsistencies and making recommendations for eliminating them. The Secretary would then be required to submit to Congress the report and a report containing legislation to eliminate the inconsistencies identified by the task force.

The Department of Justice has constitutional objections to this provision. We would support this provision if those objections are cured. We believe that the Secretary should, after reviewing the task force's report, submit a report to Congress on the inconsistencies and state what steps, legislative or otherwise, the VA would take to eliminate the inconsistencies. Requiring a report to Congress containing legislation is unnecessary.

RECRUITMENT, RETENTION AND OTHER PERSONNEL MATTERS

Mr. Chairman, I next turn to legislative measures which would impact on VA personnel matters, particularly S. 947, a bill you recently introduced which contains provisions aimed primarily at helping us recruit and retain highly qualified health care professionals. We are all aware of the difficulties VA is experiencing in many locations recruiting and retaining various health-care professionals. We support some of the legislative proposals before us today, and oppose others. We can all agree, however, that some action will be necessary to enable us to obtain those critical manpower skills that are essential to meeting the health-care needs of veterans.

As you are aware, an internal nurse pay task force has developed ideas of our own for restructuring the nurse pay system. Those ideas are still being reviewed and fine tuned. However, seeking decentralization and greater local flexibility have been hallmarks of that group's efforts. We recommend deferring action on a restructuring of the title 38 pay system, altering overtime, and making changes to the premium pay provisions until all task force proposals can be fully developed and reviewed, and until proposals can be submitted through the normal legislative process.

Nurse Pay Structure

Section 101 of S. 947 would completely restructure the pay system for VA's registered nurses, nurse anesthetists, and other health care positions the Secretary determines should be brought under the system. It would change the pay system from one using a national pay rate schedule, to one involving locally established pay schedules tied to pay rates surveyed in each local community. Although the proposal contains features which we support such as greater pay flexibility and greater decentralization of the paysetting process, it would also have many problems. It is not a proposal we can support.

Under the proposed system, each health-care facility director would survey the entry-level compensation for corresponding health-care positions in comparable non-VA facilities in the same labor market, and repeat the survey process annually. Procedures would be established by regulation to determine the number of non-VA facilities to be surveyed. However, if there were an insufficient number of facilities in the local labor market, or not enough comparable health-care positions, the director could recommend basing rates on a survey of another comparable labor market, subject to review by the Chief Medical Director. Following the survey, facility directors would prescribe pay schedules starting with a minimum rate competitive with the entry-level rates at the non-VA facilities, and make corresponding increases or decreases in all other rates within grades. These new schedules would replace existing special salary rates now authorized under 38 U.S.C. § 4107(g). Pay for entry level positions could not exeed the maximum pay rate for grade 13 on the General Schedule, except for managerial or supervisory positions. Pay for those positions could be as high as the level V Executive Schedule pay cap. Under the new "survey system," although directors could increase or decrease pay rates, no employee would suffer a pay loss if the salary rates were decreased, provided the employee continued to serve in the position at the facility.

While we do not support your specific proposal, we would point out some of the positive as well as negative features of the measure. Some features we find positive are contained in other bills pending in Congress, notably H.R. 1199, as well as in yours. First, as the proposal would provide, we believe continued use of a matrix that includes pay rates, "steps" within grades, and separate grades, is essential. Equally important, we believe, is maintaining in any system the authority to adjust pay to meet local market conditions. "Locality" pay discretion may be a central feature of any effective pay system for the future. We also support giving VA the discretion to include health-care professions in addition to nurses in any new system, provided there are recruitment and retention difficulties in those professions. There is also a place for some local wage surveying. Surveys are now conducted as part of the process of determining the special salary rates in effect at many of our facilities. However, specifying in statute the frequency of each local survey presupposes that market place changes occur with regular frequency and is, we believe, overly prescriptive. We also object to the extensive reporting requirements this section would impose.

Removing Cap On Nurses' Overtime Pay

Section 102 of S. 947 would remove the existing ceiling on overtime pay for nurses in higher pay grades. Current law permits payment of overtime at one and one-half times a nurses basic pay rate, but caps the overtime rate at one and one-half times the basic rate for a nurse in the intermediate pay grade, step one. This section could be a useful tool for furthering our efforts at retaining our most experienced and qualified nurses, those who are above the intermediate pay grade.

"Additional" Pay Provisions

Section 103 of S. 947 would provide a 6% pay differential for a nurse assigned to a head nurse position for at least 30 consecutive days, and section 106 would authorize a 1% pay differential for any nurse who is recertified in a specialty in which the nurse is employed. Finally, section 8(a) of S. 574 would provide the Secretary with discretionary authority to enhance the premium pay of nursing assistants if necessary for recruitment and retention. Our task force is reviewing the proposals to allow increased pay for head nurses, premium pay for nursing assistants, and premium pay for specialty recertification.

The head nurse position is one which is often difficult to fill without some increased incentive. The 6% increase could help provide that incentive. We oppose, however, the provision which requires that the additional pay for head nurses be considered as basic pay for purposes of other employment benefits such as insurance and retirement benefits. In our view, the additional pay is a type of premium pay. The law does not treat any other form of premium pay as basic pay for title 5 benefit purposes. As a case in point, S. 947 provides that the proposed premium pay for nurses who are recertified in a specialty would not be treated as basic pay for purposes of those other benefits.

With respect to premium pay for nursing assistants, this provision would add nursing assistants to that list of professions to whom the VA may provide enhanced premium pay if it is needed. We do not have system-wide problems recruiting or retaining nursing assistants. This measure would give VA officials more flexibility when seeking tools to alleviate any problems we do have, and we support the provision.

The additional pay for specialty recertification, on the other hand, would not provide a significant additional recruitment or retention incentive. We currently have authority to advance a nurse's pay from 1 to 5 steps within a grade based on attainment of certification by a national professional organization, and demonstration of a high level of job performance. The system we already have of recognizing nurses who obtain certification is preferable as it allows flexibility in the number of steps which we may grant, it gives a continuing monetary benefit, and it provides for considering of an employee's performance.

Military Retired Pay

Section 104 of S. 947, and section 8(b) of S. 574 would expand VA's existing authority to grant exceptions to a required reduction in retired military pay for health-care professions in addition to physicians. The S. 574 provision would expand the exception authority to registered nurses only, while your bill would permit exceptions for any personnel involved in providing either direct patient care, or services incident to direct patient care. These provisions represent a means of improving VA competitiveness. We strongly favor enactment of the change, but we prefer your bill which would permit exceptions for a wide array of health-care workers, provided we are having recruitment difficulties. Thus, we support section 104 of S. 947. It should be noted that although this provision will not increase VA outlays, it will continue outlays for military retired pay.

Section 5532 of title 5, United States Code, now imposes upon retired officers of the uniformed services, a substantial reduction in their retired pay when appointed to civilian positions in the Federal Government. Under that section, the former officer's retired pay, following appointment, is reduced to an amount equal to $7,696.51 plus half the remainder of his retired pay. (Originally the base figure was $2,000; the statute authorizes an increase keyed to Consumer Price Index increases.) The statute also imposes an overall effective ceiling equivalent to Executive Level V ($75,500), upon the aggregate of retired pay and civilian pay.

Naturally, this reduction makes Federal employment, including VA employment, less attractive for retired military health care officers. We now have authority in 38 U.S.C. § 4107(i) to authorize exceptions to the statutory loss of pay for well-qualified physicians. Exercised infrequently and, we believe, prudently, the authority has nevertheless been particularly helpful in selectively recruiting highly qualified physicians in a variety of scarce categories. In our view, allowing VA to relieve retired military health-care personnel from the required reduction would attract many more of these individuals to VA employment when they retire from the uniformed services. This expansion would be particularly helpful in recruiting and retaining nurses at facilities experiencing nursing shortages.

While we support section 104 of S. 947, the Administration also urges that equivalent authority be provided for the Secretary of Defense. To provide the Secretary of Veterans Affairs authority to grant exceptions to the restrictions in section 5532 of title 5, United States Code, while failing to provide reciprocal authority to the Secretary of Defense, will further exacerbate DoD's difficulties in attracting and retaining health care professionals.

Raising the Cap on Special Salary Rates

Section 105 of S. 947 would allow VA to approve special salary rates exceeding the maximum rate of the regular pay rates by two times, rather than the currently permitted one time. It also requires that, whenever a special rate is authorized that is at least 94% of the maximum allowable rate, VA must report that fact to the Veterans Affairs Committees of Congress.

Finally, the section would reduce from 90 days to 45 days, the period during which the Office of Personnel Management must either approve or disapprove special salary rates proposed for title 5 employees. We do not support raising the overall cap on special salary rates.

We are presently evaluating ways of revising the basic pay schedule which would greatly reduce the need for special salary rates. Therefore, a broad expansion of the special salary rate authority is not desired at this time. However, we can support a more restrictive measure which would increase the authorized special rate for intermediate grade registered nurses at the small number of VA medical centers which are presently paying 90% or greater of the maximum allowable rate. This will allow us to remain competitive in certain areas of the country where we are now "bumping up" against the special rate cap. We do not object to the reporting requirement, nor do we object to the change in the review period given to OPM as, in most cases, the full 90 days is not now being used.

Health-Care Professionals' Cash Awards

Section 201 of S. 947 would direct the Secretary, by regulation, to establish a program to pay cash awards to full-time physicians, dentists, podiatrists, optometrists, nurses, physician assis- tants, and expanded-function dental auxiliaries who serve as supervisors or managers. The minimum award under the program would be 5% of the individual's basic pay, and the maximum could be 20%. Not more than 20% of the individuals in each of the eligible professions could receive an award. Finally, any cash award would not be considered basic pay for purposes of other employee benefits such as insurance or retirement.

We know that rewards for exemplary managerial or supervisory skills encourage continued exemplary performance. Special "step" advancements for performance are already authorized under Department policies pursuant to section 4106(c) of title 38 for title 38 employees. However, there is not now any specific provision in title 38 for cash performance awards for those employees. We are not opposed to enacting explicit authority in title 38 for cash performance awards for title 38 managers and supervisors, but we cannot support this proposal as it is drafted. First, we are concerned that it is not just managers and supervisors who merit recognition through monetary awards. Many health-care professionals who are on the "front lines" providing direct patient care are also deserving, but would not be included in this provision. Also, many exemplary employees work part-time, and would also be ineligible for an award whether they are a manager or supervisor, or not. We therefore favor explicit authority for recognizing, through cash awards, the performance of title 38 employees, both nonsupervisors and supervisors or managers.

Our second major concern is that the award limits cover too wide a range. The 5% to 20% (of basic pay) range for the awards that is contained in your bill equates roughly to those awards given to Senior Executives rather than managers and supervisors. We would prefer that the provision not impose a minimum, or that it at least be reduced to 2%, and that the maximum be limited to 10%. These are the limits provided under title 5 for general schedule employees. Furthermore, we believe that there should not be a limit on the percent of personnel receiving such awards. This is consistent with title 5 cash awards for general schedule employees. If, however, it is decided to maintain a limit, we would prefer a cap of 5% (1 out of 20 employees). This would make the awards more meaningful in terms of motivation or acknowledgment. In our view that would make the award provision more equitable and more reasonable from a cost standpoint. Finally, if this legislation were enacted, we would require sufficient time to review the existing proficiency rating system for title 38 employees to determine what adjustments will be necessary to relate performance to specific award criteria.

Dependent Care Assistance Program

Section 202 of S. 947 would direct that the Secretary establish what is known as a "cafeteria plan" for employees working in the Veterans Health Services and Research Administration to assist them in meeting dependent care costs. Under such plans, an employer, at the request of an employee, may withhold funds from the employee's paycheck and deposit them in a special account which the employee may then use for paying child or dependent care expenses. Section 129 of the Internal Revenue Code, 26 U.S.C. § 129(a), authorizes employers to exclude funds deposited in such accounts from the gross income of the employee up to $5000 ($2500 in the case of a separate return filed by a married individual). The effect of the cafeteria plan allocation is thus to reduce the employee's federal income tax. It is our understanding, however, that an employee participating in a "cafeteria plan" may not use the tax credit for child care expenses. Employees would have to assess whether the child care credit, or the cafeteria plan, is most advantageous to them from a tax standpoint. Thus, the opportunity to participate in a cafeteria plan may not necessarily be attractive to all employees who would be eligible to participate. As a result, we have no estimates of the tax revenues that Treasury would forego. Nevertheless, we do not object to this section of S. 947.

Leave Transfer and Leave Banks

Section 203 of S. 947 would direct the Secretary to establish a voluntary leave transfer program, and permit creation of a voluntary leave bank program, for the benefit of title 38 health-care employees. S. 899, our proposal which you recently introduced at the request of the Administration, would give the

Secretary discretion to establish a 5-year temporary leave transfer or leave bank program similar to that provided for title 5 employees. We urge adoption of our discretionary provision, S. 699, and oppose section 203 of S. 947.

Under revised OPM regulations, leave transfer programs allow covered employees to apply, based on a medical emergency, for eligibility to use the unused and accrued annual leave of other employees. Medical emergency generally means a medical condition of an employee or family member of the employee that is likely to require the employee's absence from duty for a prolonged period of time, and will result in a substantial loss of income to the employee because of the unavailability of paid leave. Employees who wish to donate leave submit voluntary written requests specifying the amount of leave they wish to donate. The donating employee's account is then reduced by the amount of leave he or she asked to donate and the eligible recipient's leave account is augmented. When the emergency terminates, unused donations of leave are restored to the appropriate donors. Employees may not donate leave to their immediate supervisor or generally give more than half the leave they accrue during the year of the donation.

Under section 203 of S. 947, both the leave transfer and leave bank programs must, if feasible, provide the same or similar requirements and conditions that are prescribed for the leave transfer and bank program administered by OPM. As one means to accomplish its purpose, the section also authorizes the Secretary to enter into an agreement with the Director of the Office of Personnel Management to permit VA health-care employees to participate in the OPM-administered leave transfer and leave bank programs. If the Secretary chooses the latter option to reach an agreement with OPM, he or she need not provide a VA administered program.

Under our proposal, we would anticipate having only a leave transfer program to be used by both title 5 and title 38 employees, which would permit the donation of leave between both groups. We would not exercise authority to establish a leave bank program at this time. Because the banks are administratively cumbersome to operate, OPM is operating leave bank programs on a limited test basis with agencies that volunteer to participate. We believe it would be appropriate to defer any legislation on a leave bank until the OPM pilot projects can be more fully evaluated.

Health Professional Scholarship Program

Section 301 of S. 947 would amend the law authorizing the VA's Health Professional Scholarship Program to provide that inselecting participants for the program, the Secretary shall ensure an equitable allocation of scholarships to persons in the second year of programs leading to an associate degree in nursing. We oppose the provision.

VA currently has educational assistance programs which authorize support to candidates for associate degrees in nursing, making this provision unnecessary. Both the tuition assistance program authorized by title 5 (5 U.S.C. § 4109), and the upward mobility program (MP-5, Part I, Chapter 410, Appendix A), provide such assistance. Moreover, the soon to be implemented tuition reimbursement program (38 U.S.C. §§ 4321 et seq.), will also support associate degree candidates. The Scholarship Program has always been used as a tool to recruit new baccalaureate or masters level nurses into the VA system. This Program coupled with the Tuition Support, Tuition Reimbursement and Upward Mobility Programs, provides for a well balanced spectrum of education programs for clinically focused care givers in VA Medical Centers.

Grants to Affiliated Allied Health Institutions

Section 302 of S. 947 would authorize the appropriation of $5 million in FY 1990 and 1991 and $6 million for each of the following two years for grants to allied health institutions. We do not believe the proposal has sufficient priority to warrant funding at this time. We do not question that this concept may have merit, but we would certainly not seek to fund it at the expense of other more urgent demands on our health care system.

Appointment of Graduates of Affiliated Programs

Section 401 of S. 947 would authorize VA to appoint graduates of affiliated "allied" clinical health-care education programs to competitive civil service positions without regard to competitive civil service procedures. We would support this provision with revisions to preclude departure from merit principles by ensuring that only qualified persons are hired.

Under our statutory health-care education mission, we operate clinical education programs in our facilities which annually train approximately 50,000 students in allied health-care occupations, including psychology, social work, audiology, speech therapy, dietetics and recreational therapy. Yet, the complicated and often lengthy civil service process discourages many highly-qualified allied health-care graduates of VA-affiliated clinical education programs from taking jobs with the VA. By the time these graduates complete the process for placement on a civil service register, and are certified to the VA, other health care employers have often already hired them. As a result, we lose potential employees who are already VA-trained. We are currently experiencing staff shortages in some of these positions. This proposal would enable us, without jeopardizing merit principles, to directly hire graduates of proven competence, who already are familiar with our methods, without regard to the competitive service certification process. We would support the provision with an amendment requiring VA, by regulation, to establish minimum requirements to be met by applicants hired under a waiver of the civil service procedures. This would insure that only those candidates who are clearly well qualified receive special treatment. We would also recommend that it be expanded to include residents and other trainees in health-care management occupations.

There are no significant costs or savings associated with this proposal. However, our ability to hire these highly-qualified graduates would reduce administrative costs associated with the recruitment, orientation and training of new employees. We favor its enactment.

Pay and Personnel Management Pilot Program

Section 402 of S. 947 would require the Chief Medical Director (CMD) to conduct during calendar years 1990, 1991, and 1992, pilot programs at not less than five VA medical facilities with respect to determining the desirability of various pay and management practices, including those required to be studied by section 231 of Public Law 100-322, relating to the recruitment and retention of registered nurses and other scarce health-care professionals. Specifically, the programs are to include: new alternatives for utilizing the skills and knowledge of registered nurses in furnishing direct-patient care; collaborative-practice committees; and significantly increasing evening and night shift pay differentials. Finally, the bill calls for elaborate reporting to the Senate and House Veterans Affairs Committees both during the pilot program and at it conclusion.

At this time, we have not completed our review of the contractor's report of the study commissioned under section 231 of Public Law 100-322, which addresses such matters as the effects of pay and personnel management practices of VHS&RA on reruitment and retention of health-care employees and the desirability and feasibility of flexible benefit programs. We acknowledge that certain pilot program proposals would provide a test of some of the study findings. We believe it would be appropriate, however, to defer support of further pilot programs until we fully assess the contractor's findings, and determine what the scope of any pilot program should be.

Collective Bargaining/Disciplinary Reform/Grievance Procedures

Sections 223 and 224 of S. 13 address matters which were involved in the the July 1988 decision in Colorado Nurses Association v. FLRA, 851 F. 2d 1486 (1988). Section 223 would statutorily overturn that decision. Section 224 would statutorily mandate a union grievance procedure for title 38 medical professionals. We strongly oppose both sections.

Section 223 would effectively reverse the court decision by statutorily imposing on the Secretary the obligation to bargain concerning conditions of employment for title 38 employees that is contained in chapter 71 of title 5, United States Code. Section 4108 of title 38, United States Code, currently reserves to the Secretary the authority to prescribe conditions of employment. Particularly with respect to clinical and professional matters directly affecting the quality of the health care being delivered in VA medical facilities, the Department has sought to preserve the traditional medical peer review process. The latter process is inconsistent with significant aspects of the collective bargaining requirements contained in the title 5 provisions. Peer review, a hallmark of the independent title 38 employment system Congress established in title 38 to enable VA to ensure competence among its professional staff, continues to be an essential element of effective health care delivery. VA has been so strongly committed to the peer review principle that, over the past 15 years, it has litigated aggressively to resist collective bargaining proposals inconsistent with it. The litigation, with strong Department of Justice support, culminated in the Colorado Nurses case. We strongly oppose section 223 which would reverse the court's decision.

Section 224 would eliminate the current requirement that a disciplinary board be conducted where management proposes against a "title 38" health care professional employee, a "lesser" disciplinary action, i.e., suspension for 14 days or less, reassignment without reduction in basic pay, reduction in rank without a reduction in basic pay, reprimand, or admonishment. For these actions, the section would substitute a due process system, including either arbitration or an agency review procedure, depending on bargaining unit status of the affected employee. Section 224 would also require that the Secretary authorize arbitration of grievances for employees in bargaining units. The section addresses peer review, the principle under which professional, clinical matters are reviewed only by qualified professionals, by requiring that arbitrators on the disciplinary actions covered by the section be qualified to examine and adjudicate health care issues or be qualified as a physician, dentist, or nurse.

Mr. Chairman, our disciplinary procedures do need streamlining. We need better procedures for situations involving "lesser" disciplinary actions. Section 224 is not the right approach, however. It would be inconsistent with our longstanding position in litigation that disciplinary matters affecting title 38 employees are not appropriate subjects for grievance arbitration. Nor do we believe grievances over more general working conditions including issues involving clinical and/or professional matters should, consistent with our position in the Colorado Nurses case, be subjects for negotiated grievance procedures. As an alternative, we recommend the approach taken in S. 1136, and H. R. 2009, in the

100th Congress. Those bills would have limited the use of the disciplinary board machinery to cases where the proposed penalties are most serious: removal, suspension of more than 14 days, or demotions involving loss of grade or basic pay. All lesser disciplinary actions would have been excluded. Administrative appeal or grievance procedures would have been established for these latter actions under regulations prescribed by the Administrator pursuant to current authority. As a result, the volume of section 4110 disciplinary actions would have been reduced. Moreover, lesser disciplinary actions would have been less costly and cumbersome, and therefore more readily invoked. That would make progressive discipline more feasible, and allow preservation of management prerogatives.

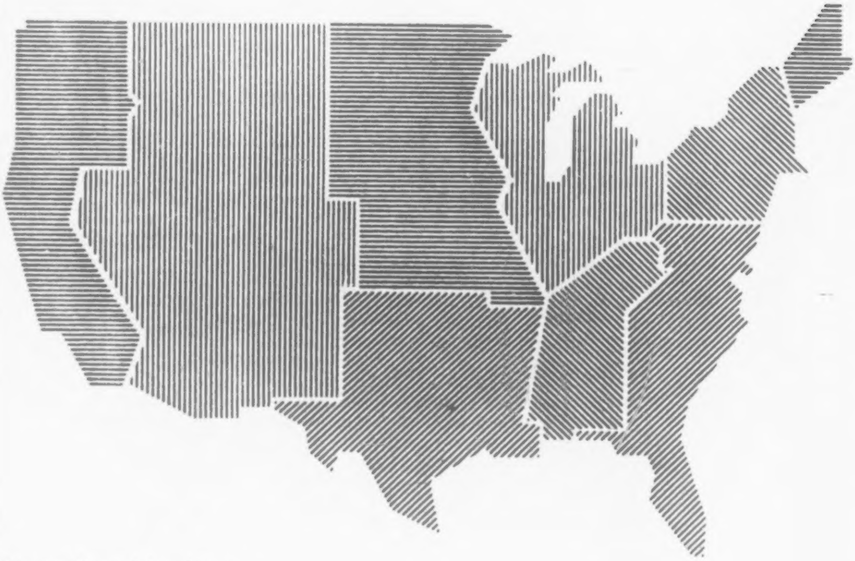
THIRD PARTY COLLECTIONS

S. 573 would permit VA to recover from health insurers the cost of care furnished to a service-connected veteran for a nonservice-connected disability. Under current law, the United States may recover from crime victims' programs, under automobile reparations and workers compensation laws, and from health insurance plans, the cost of medical care furnished by the Department of Veterans Affairs for nonservice-connected disabilities. However, with respect to health insurance, we are prohibited from collecting for care if the veteran has a service-connected disability. That is the case even though the care is furnished for a nonservice-connected disability. This bill would permit insurance recoveries for all care for nonservice-connected disabilities. By allowing insurance recoveries in those cases, as well as recoveries from the other sources (workers compensation, tort recoveries, and crime victim programs), VA's medical care cost recovery program would be more consistent. Moreover, it is our view that where a veteran has paid premiums for health care coverage, it is only reasonable that the Government should recover it's cost of care from the insurer when the veteran receives the care in a VA facility. This is especially so when, as would be the case, the recovery by the United States has no measurable impact on the veteran.

Currently, all collections are deposited in the Treasury as miscellaneous receipts. For funds collected from insurers of service-connected veterans, we propose that 50% be legitimately retained in the VA. Some of these funds would be used to reimburse VA for the costs of contracting for collecting and billing.

Mr. Chairman, this concludes my prepared statement. My colleagues and I would be pleased to respond to any questions you may have.

Report of the Hospital Nursing Personnel Survey 1987



American Hospital Association

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II. NURSING LABOR COSTS, BENEFITS AND COLLECTIVE BARGAINING ACTIVITIES

Nursing Labor Costs (Tables 2.1a - 2.1d)

The mean average hourly expense (total direct and indirect expenditures/total hours paid) for a registered nurse was $12.70 (S.D. $3.04). This was a small increase (4%) over the $12.17 mean reported in 1985. The average lowest annual salary for a full-time registered nurse in a staff nurse position was $20,205; the average highest annual salary was $26,729. Significant differences in expenses and salaries were found to occur based on hospital location and size and the surrounding area's population density. The interrelationship of these factors and their effect on expense and salary are under examination. Anecdotal and media reports indicate that 1987 expenditures and salaries may have risen markedly after the April, 1987, data collection period.

The percentage of hospitals which provided a wage differential for evening (97%) and night shifts (98%) remained identical statistically to those noted in 1985. The percentage of hospitals providing weekend differentials increased from 29.9% in 1985 to 32% in 1987. The percentage of hospitals which paid a differential for ICU/CCU units increased from 25% to 29.2%. The average amount of the differentials paid by the hour increased somewhat since 1984 (the last year for which comparable data are available). The average wage differential per hour for evening shift in 1984 was $0.70; in 1987 the average was $0.79. In 1984 the average night shift differential was $0.90; in 1987 it was $1.02. Average weekend shift ($0.86 versus $1.09) and ICU/CCU ($0.41 versus $0.63) average differentials showed the greatest increase.

Respondents to the survey were asked to indicate if differentials were paid by as a flat hourly rate or as percentage of salary. Of hospitals which paid a differential, approximately 17% paid evening and shift differentials as a percentage of base salary. Approximately 25% of hospitals who paid weekend differentials provided them as a percentage of base salary. The mean evening shift differential was 9% and the mean night shift was 12% of base salary. In hospitals which indicated paying a weekend differential as a percentage of base salary, the average was 21% of salary.

Payment of differentials for baccalaureate and master's prepared RNs and for holders of specialty certification was provided by a small percentage of hospitals (19%, 10% and 11% respectively). The average hourly differential rate was $0.28 (S.D.=$0.23) for the baccalaureate prepared RN, $0.31 (S.D.=$0.12) for the master's prepared RN and $0.34 (S.D.=$0.23) for the holder of a specialty certificate. Of the hospitals who paid differentials for educational preparation and indicated the amounts, 30% paid for the baccalaureate differential as a percentage of base salary; approximately 35% of hospitals paid master's and certification differential as a percentage of base salary. The average percentage of base salary differentials were 4% (S.D.=2%) for the baccalaureate prepared RN, 6% (S.D.=4%) for the master's prepared RN and 4% (S.D.=1%) for the holder of a certificate.

There were no differences based on location or other characteristics in the percentage of hospitals who offered evening and night shift differentials; there were marked differences in the amount of differential offered. There were significant differences in the percentage of hospitals who offered weekend and ICU/CCU differentials and the amount offered if location and population density are considered.

Benefits (Tables 2.2a - 2.2b)

Dental insurance was provided to full-time RN employees by the majority of hospitals (62.5%) at a mean rate of 85% of costs. Dental insurance was provided by almost all hospitals of 500 or more beds (93.2%), those in the Pacific region (93.8%) and most hospitals in urban areas of over 1 million population (82%). Hospitals reporting a moderate to severe nursing shortage had a slightly higher rate of providing dental insurance as did those in which RNs are organized for collective bargaining (76%).

Child care was a benefit provided by only 6.1% of hospitals surveyed. When offered, only an average of 23% of costs were covered by the institution. (The small number of respondents to this item limit generalizability). Almost a third of very large hospitals (≥500 beds) provided this benefit. Approximately 13% of hospitals in major urban areas provided this benefit. Hospitals reporting a severe shortage of RNs were twice as likely to provide child care as those reporting no shortage (7.8% versus 3.3%).

Tuition reimbursement was a common benefit, provided by 72% of hospitals at a mean rate of 84% of costs. Tuition reimbursement was less likely to be provided to RNs in hospitals with less than 100 beds, those in Midwest regions, those in non-federal government hospitals or in rural areas.

Professional membership fees were paid by 12% of hospitals at a mean rate of 85% of costs. This benefit was slightly more common in the New England region.

Payment of the costs of acquiring a clinical specialty certificate was provided by 25.4% of hospitals at an average of 86% of costs. New England and Mid-Atlantic region hospitals were more likely to provide this benefit.

Almost all hospitals (95.9%) paid some RNs for days spent at continuing education (CE) activities. The majority (55.1%) varied this benefit according to CE program or the employee's position; the remainder applied a standard policy. In addition to salary, most hospitals paid these RNs' registration fees, transportation costs and lodging expenses. Payment for any of these direct expenses was usually related to the purpose of the CE program or the employees' positions. Lodging and transportation costs were less likely to be paid by hospitals in large urban areas.

Collective Bargaining (Tables 2.3a - 2.3b)

The percentage of hospitals who reported that their registered nurse staff were organized for purposes of collective bargaining increased from 12.9% in 1985 to 14.8%. Major urban centers and the Middle Atlantic and Pacific regions had the highest proportions of hospitals indicating RN collective bargaining. Hospitals of 200-299 beds and very large institutions (≥ 500 beds) reported organization at 1.5 times the national rate. Investor owned institutions were approximately half as likely to have RN bargaining units; conversely, 19% of non-federal government hospitals were organized.

State Nurses' Associations were the agents in 60% of organized hospitals; unions (26.7%) were a distant second. Employee associations/internal bargaining units were representatives in 13.3% of the organized hospitals. The Middle Atlantic had the highest proportion (34.6%) of organized hospitals in which RNs were represented by unions. Employee associations/internal bargaining units were confined to the South Atlantic, East North Central, West North Central, West South Central and Pacific regions. Unions represented RNs in a higher proportion of non-federal government and investor owned hospitals. Only 5.9% of small hospitals (<50 beds) reported union representation. Employee associations, which were not reported by any hospital of 300 or more beds, were most prevalent in these small institutions.

Only 2.3% of hospitals reported an organized interruption of regular work by full-time RNs. This figure is statistically similar to the 3.7% reported in 1985 and the 3% reported in 1984. Approximately one-third of the interruptions were slowdowns rather than strikes. The majority of interruptions occurred in hospitals with less than 300 beds, those in rural or small, urban areas and those operated by non-profit organizations. Length of work interruption ranged from 1 to 180 days (mean = 55) with usually less than 50% of represented RNs participating (mean = 39%). Causative issues identified as "very important" by almost three quarters of the hospitals which experienced interruptions were patient - RN ratio (73%), salary (76.9%) and benefits (71%). Management - RN relationships were cited as very important or somewhat important by every hospital.

The following information was abstracted from the Department of Labor, Bureau of Labor Statistics publication Industry Wage Survey: Hospitals, August 1985. The data pertains to full-time general duty nurses only.

Metropolition Area	Employees Organized	Percent	Employees Not Organized
Boston	3,390	37	5,732
Buffalo	1,574	52	1,475
New York	19,560	80	4,823
Philadelphia	2,097	15	11,970
Atlanta	0	0	2,612
Baltimore	1,126	19	4,839
Dallas	0	0	7,246
Houston	0	0	6,684
Miami	0	0	3,258
Washington, DC	1,337	17	6,351
Chicago	2,729	15	15,792
Cleveland	0	0	4,805
Detroit	1,210	13	8,301
Kansas City	0	0	3,925
Milwaukee	0	0	2,578
Minneapolis	1,633	100	0
St. Louis	240	03	8,027
Denver	0	0	4,167
Los Angeles	3,813	31	8,676
Oakland	1,600	81	369
Portland	1,016	53	900
San Francisco	2,092	93	157
Seattle	2,575	100	0

TESTIMONY OF THE NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES TO THE STATE COMMITTEE ON VETERANS AFFAIRS REGARDING RECRUITMENT AND RETENTION OF HEALTH CARE PROFESSIONALS

Pages 2-4 VAMC COATESVILLE, PENNSYLVANIA

ALLEGATION: At the Coatesville VA for instance there are severe staff shortages among the RN's and LPN's. The hospital is authorized to have 123 LPN's, but has 49 vacant LPN slots, and 219 authorized RN slots with 42 vacancies. The hospital is filling substantial numbers of these vacancies by using nursing assistants. The hospital has 230 nursing assistant slots authorized, but actually employed 290 nursing assistants with 60 Nursing Assistants functioning as RN's and LPN's. Thus almost one quarter of the professional nursing slots at Coatesville are filled by Nursing Assistants.

RESPONSE: This statement is absolutely not true.

Local NAGE President is very disturbed over this document and is in the process of writing the National President voicing his concerns.

ALLEGATION: Nursing Assistants working out of grade.

RESPONSE: The local union is very protective of its members and one thing is for sure - if an employee is "working out of grade" it is brought to management's attention immediately and is corrected. Incidentally, such cases are few and far between.

Mr. Edward Murphy, author of this document, is in the process of drafting a "new" document that he plans on sending to the Chairman of the Senate Committee on Veterans' Affairs in an effort to correct "misleading/misunderstood" information.

ALLEGATION: Even with these measures staffing is so short that management has been forced to institute several other extraordinary measures in an attempt to maintain service. Virtually every day staff is ordered to work mandatory overtime and even relatively compelling family commitments do not excuse the nurses from overtime assignments. As a compromise, however, it has become a standard practice to permit personnel on mandatory overtime without child care arrangements to bring their children to the nursing station until child care can be arranged. As Coatesville is one of VA's largest psychiatric hospitals, this arrangement must trouble many parents.

RESPONSE: There is no such standard practice - in almost 3 years since arriving at Coatesville, the Director knows of only 1 instance where a child was brought to the facility by his mother because another employee, the child's father, working a different schedule, took the child to school at the conclusion of his shift.

ALLEGATION: In addition the local union is troubled by staffing patterns caused by shortages which leave one nursing assistant alone on a locked ward with patients considered dangerous.

RESPONSE: There is never an instance when only one nursing assistant is scheduled for a locked ward. If an emergency occurs, other Nursing Assistant's are reassigned from other units, or overtime is authorized to provide coverage. Staffing shortages have no bearing on assignments to locked wards.

ALLEGATION: Staffing is so short that RN's are unable to give or receive a 24-hour report of what happened in the previous shift.

RESPONSE: This is entirely untrue. A report is always made.

ALLEGATION: Finally, sick leave usage has increased dramatically, undoubtedly due to the long hours of work and the difficulties experienced by workers in spending reasonable amounts of time with their families.

RESPONSE: Sick leave usage has not "increased dramatically." Traditionally, sick leave usage has been high for all employment categories at VAMC Coatesville, but for reasons other than long hours of work. This issue has and continues to be addressed at the Service Chief level.

TESTIMONY OF THE NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES TO THE STATE COMMITTEE ON VETERANS AFFAIRS REGARDING RECRUITMENT AND RETENTION OF HEALTH CARE PROFESSIONALS

Page 4 VAMC WEST ROXBURY, MASSACHUSETTS

ALLEGATION: At the West Roxbury VA the turnover rate in 1988 was 47% among professional staff.

RESPONSE: The actual turnover rates for Nursing Service employees at VAMC Brockton/West Roxbury (W. Roxbury Division) are as follows: RN's-23.8%, LPN's-9.1%, NA's-84.5% and the Overall Rate was 36.5%.

TESTIMONY OF THE NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES TO THE STATE COMMITTEE ON VETERANS AFFAIRS REGARDING RECRUITMENT AND RETENTION OF HEALTH CARE PROFESSIONALS

Pages 12-13 VAMC GRAND JUNCTION, COLORADO

ALLEGATION: During a three-year period when a charge of negligence was being investigated and reviewed by a Professional Standards Board, a Registered Nurse suffered financial loss since she was denied within-grade increases and promotion opportunities.

RESPONSE: The circumstances concerning loss of pay are in error. The only monetary loss of pay was night and weekend differential which is earned only when worked. She retained full RN salary during the process.

The within-grade was withheld during the proceeding but was retroactively approved and paid at the time of final decision. VA paid for and gave administrative leave to attend college refresher course.

ALLEGATION: The timeframes of the process were cumbersome.

RESPONSE: The comments about the extensive timeframes from the date of incident to the final Agency decision are basically true.

ALLEGATION: Her professional reputation was damaged.

RESPONSE: Every effort was made to prevent any appearance of damage to this person's professional reputation. VA provided an extensive re-orientation on-station before assigning to full duty. Close supervision and guidelines was provided by immediate supervisor.

TESTIMONY OF THE AMERICAN NURSES' ASSOCIATION ON VETERANS' AFFAIRS RECRUITMENT AND RETENTION

Pages 13 VAMC NORTH CHICAGO, ILLINOIS

ALLEGATION: In North Chicago, the Illinois Nurses' Association reports that if the chemotherapy nurse is on leave or ill, there is no replacement; therefore, no chemotherapy is provided.

RESPONSE: The statement is not correct. For the past few years, the chemotherapy administration workload has not been high enough to require more than one R.N. in this assignment. The chemotherapy nurse coordinates her vacation coverage with the oncology section physician. The physician then provides chemotherapy in her absence. Although this arrangement has worked out well for both planned and unplanned absences, the Chief of Staff, VAMC North Chicago is reviewing the need to train a back-up nurse.

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

TESTIMONY

OF THE

AMERICAN NURSES' ASSOCIATION

ON

VETERANS' AFFAIRS

RECRUITMENT AND RETENTION

BEFORE

THE

SENATE VETERANS' AFFAIRS COMMITTEE

PRESENTED

BY

MARGARET C. STAFFORD, M.S.N., R.N., F.A.A.N.

MAY 18, 1989

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Mr. Chairman, I am Margaret C. Stafford, M.S.N., R.N., F.A.A.N., a Clinical Nurse Specialist at the Hines Veterans Administration Medical Center. I am a member of the Illinois Nurses Association (INA) which represents registered nurses (RNs) in collective bargaining at the Hines, North Chicago and Westside Veterans' Administration Medical Centers.

The 188,000 members of the American Nurses' Association (ANA) and its 53 constituent state nurses' associations, appreciate the opportunity to address the veterans' health care and recruitment and retention of nurses within the Veterans' Affairs (VA). A significant number of ANA members are VA nurses. In addition, ANA has represented VA nurses in collective bargaining since 1967 through its state nurses' associations.

Our message is clear -- all is not well in VA hospitals. In fact, if the VA health care system were a patient, we would describe its condition as "critical." There is no doubt that this condition will deteriorate if meaningful measures are not taken.

This hearing reflects the committee's continued commitment to the provision of quality health care for the men and women veterans of our nation. The committee has been instrumental in improving working conditions for nurses; guaranteeing nurses the right of collective bargaining; encouraging nursing career development; providing educational opportunities; promoting clinical nursing research; and fostering the critical inclusion of nursing within the Veterans' Administration health care system. The committee has also stressed the inclusion of women veterans within the VA programs. Those policies have done much to ensure quality nursing care for all veterans. It is our hope that the committee will continue to address the needs of the patients and health care personnel so that we may improve not only the quality of care rendered to veterans but also access to the health care system.

The nation's hospitals including the VA are facing a critical nursing shortage. This is occurring at the same time the VA is facing an influx of older and sicker patients. These veterans are more seriously ill. Their care is complicated by factors of age, the presence of chronic illnesses affecting many body systems, the use of highly technological treatments, pressures for early discharge, and the rapid increase in the number of patients with acquired immune deficiency syndrome (AIDS).

The needs of patients in today's health care system require the care of RNs. The surging demand for nurses, a major factor in the national nursing shortage, provides evidence that efficient, effective utilization of qualified, experienced RNs is needed to preserve quality of care within the limits of cost containment. Unfortunately, this increased demand occurs during a nursing shortage crisis experienced throughout the public and private health care arena.

S. 13 - "The Veterans' Benefits and Health Care Act of 1989"

ANA has reviewed S. 13 and supports the bill as a comprehensive benefits package which facilitates rehabilitation and education of disabled veterans. However, we do have some concerns and would like to address those here today.

Section 211 requires the VA to furnish services to help a veteran or a veteran's spouse to achieve pregnancy in cases where a service connected disability impairs procreative ability. ANA shares your concern that the increasing number of female veterans must be provided equal access to health care services. We have supported the committee's efforts to assure that the VA be sensitive to the needs of all our nation's veterans. ANA has worked with the VA's Advisory Committee on Women Veterans since its inception.

As health care providers, nurses have a long and proud history of support for a fair and equitable health care delivery system in which all Americans have access to basic health services, including services related to reproductive health. The foundation of such a system rests on the broader social rights of privacy, free speech, freedom of choice, confidentiality between client and provider, and equity of access to essential services.

ANA believes that the health care client has the right to privacy and the right to make decisions about personal health care based on full information and without coercion. It is the obligation of the health care provider to share with the client all relevant information about health choices that are legal and to support that client regardless of the decision the client may make. Procreative services such as drugs or hormone treatments, surgery, artificial insemination and in vitro fertilization and newer technologies are alternatives that are legal and that the health care provider can objectively discuss when counseling clients. If the VA limits the provision of such information to the client, an unethical and clinically inappropriate restraint will be imposed on the provider and the provider-client relationship will be jeopardized.

Just as the client has rights, the nurse also has rights, including the right to refuse to participate in a particular case on ethical grounds. However, if the nurse becomes involved in such a case and the client's life is in jeopardy, the nurse is obliged to provide for the client's safety, to avoid abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the client.

The fact that thousands of American women including veterans are seeking procreative services demonstrates the need for comprehensive care and informed providers. Health care providers have the right and responsibility to seek viable solutions to problems that effective family planning.

As one of the major national health care provider organizations, the American Nurses' Association believes it has a responsibility to continue its advocacy for a healthier nation. To this end, the ANA Board of Directors is appointing a Task Force to address Health and Social Problems and Public Policy Related to Reproductive Health. The task force will analyze reproductive health issues and initiatives and their implications for access to care, freedom of choice and the right to privacy. Recommendations from the task force will help to guide future ANA action on reproductive health.

ANA is concerned that the cost of some of these technologies may be financially prohibitive. Those costs must be addressed in light of the existing and future budgetary constraints in which the VA, other federal and private health care systems must provide health care. Additionally, some of these procedures are not successful initially and require repeated attempts. How will decisions about abandonment of such procreative technologies be made and by whom? Will those veterans who chose not to pursue physiological procreative services receive assistance with adoption services from the VA?

ANA supports the provisions in Section 212 and 213 which address compensated work therapy programs and state home construction respectively. We also support Sections 214, Pilot Program for Furnishing Assistive Animals to Certain Veterans and 215, Pilot Program for Providing Signal Dogs to Certain Veterans, as we believe that quadriplegic and hearing impaired veterans should be afforded assistive measures to increase their independence and quality of life. However, we urge the VA to assure that such programs are administered equitably and that animal rights be protected.

ANA commends the Committee for addressing security and its administration at VA medical centers in Section 221. As nurses, we recognize the need for qualified, dependable and appropriate security personnel for the protection of veterans, visitors and VA personnel.

We also support the sharing of specialized medical resources in Section 222 as we recognize the need for cost-effective provision of services. ANA believes that interagency coordination and sharing among federal health care systems administered by the VA, Department of Defense and Public Health Service should occur to increase cost-effectiveness and efficiency of care for the beneficiaries of those programs.

We would, therefore, like to address Section's 223 coverage of the Veterans' Health Services and Research Administration (VHRSA) personnel by federal employee's collective bargaining procedures and disciplinary actions and grievances.

We believe that nursing's ability to engage in effective collective bargaining must be maintained throughout the VA. The National Labor Relation Board's (NLRB) recent decision to recognize all RN bargaining units in the private sector means that the VA will have to compete even more vigorously in the provision of meaningful contracts, in addition to salaries and benefits.

We believe collective bargaining impacts health care personnel retention and recruitment within the VA medical system. Collective bargaining provides an effective mechanism for nurses to address practice and economic issues, including clinical practice decisions, orientation for new graduates, professional practice committees, patient classification systems, and staffing levels. Experts agree that wage compression is a serious deterrent to attracting young, career-minded individuals to nursing. Contract negotiations are producing genuine advances in compensation, particularly for experienced nurses. These advances in practice and economics interact to make nursing an increasingly attractive career. Efforts to recruit new candidates and retain experienced nurses have been strengthened by the collective bargaining process in the private sector, the VA must be able to respond accordingly.

ANA and its constituent state nurses' associations have represented VA nurses since the early 1960s. In August 1983, ANA was granted National Consultation Rights at the agency level of the Veterans Administration. In July, the U.S. Court of Appeals for the District of Columbia Circuit ruled that the Veterans Administration administrators' authority to issue regulations concerning the working conditions of Department of Medicine and Surgery employees, including nurses supercedes the employees' rights to engage in bargaining over those conditions. The administrator is not obligated, according to the court, to engage in collective bargaining on any condition of employment on which regulations have been issued. In the case, involving the Colorado Nurses' Association, the VA contended that it was exempt from the obligation to engage in collective bargaining with its nurses because the Department of Medicine and Surgery Statute grants the Administrator the sole authority to determine their conditions of employment "notwithstanding any law." The Colorado Nurses' Association and ANA argued that the Department of Medicine and Surgery's (DM&S) statute should be read in tandem with the Federal Service Labor-Management Relations' statute which provides that federal employees have the right to engage in collective bargaining with respect to conditions of employment. Nevertheless, in accepting the VA's argument, the court stated, "The purpose of this language is clear: when the Administrator prescribes regulations concerning conditions of employment, he is to be unhampered by the range of federal personnel statutes and regulations that might otherwise constrain his authority."

The court's decision overturns an earlier ruling by the Federal Labor Relations Authority (FLRA). The FLRA had recognized that Title 38, authorizing facility administrators to issue regulations, and Title 5 permitting collective bargaining, were not mutually exclusive. At that time, the FLRA specifically held that a proposal to establish a grievance and arbitration procedure was within the duty to bargain. However, the appeals court reasoned that, because Title 38 does not leave room for mandatory collective bargaining over union proposals relating to working conditions, the VA need not bargain over any of the proposals at issue in the case. The breadth of the current decision calls into question continued collective bargaining rights of VA nurses currently represented by state nurses' associations.

For several years, ANA and state nurses' association have vigorously fought to protect the rights of VA nurses to engage in collective bargaining. The

Colorado case represents the consolidation of common issues from cases which also involved the New York State Nurses' Association and the Illinois Nurses' Association.

ANA believes that Congress intended for the VA nurses to have the same rights and protections under collective bargaining that private sector nurses enjoy. Granting collective bargaining to Title 38 employees was essential as a recruitment and retention initiative. ANA therefore, adamantly believes the recent Court of Appeals' ruling will have an adverse impact on the VA's ability to attract health care professionals.

We agree with the Committee's review of collective bargaining, the key issue underlying this issue is the relationship between the VA personnel system under Title 38 and the General Civil Service System under Title 5. ANA believes that Title 38 employees are afforded the same labor management rights as other government employees.

As the Chairman pointed out in his January 25 floor statement, the Title 38 personnel system is a valid and valuable tool to provide the VA with greater recruitment and retention capabilities and should be maintained. Discretionary application or abandonment of Title 5 personnel procedures by the VA deprives Title 38 employees of their rights and exacerbates the recruitment and retention difficulties.

Therefore, we wholeheartedly endorse Section 223 which protects the special professional nature of Title 38 employees while assuring VA competitiveness for health care employees.

During the last Congress ANA addressed the issue of progressive disciplinary actions. At that time, we said "the disciplinary process should not make a distinction between seriousness of offenses. The proposed bill compromises the concept of a progressive disciplinary system. We do not believe that an employee's rights to due process are any less when lesser disciplinary actions are involved. It is the degree of penalty, not the extent of due process which properly fluctuates with the seriousness of the infraction. Additionally, the employer often relies on a chain of lesser actions as a reliable indication of a more serious disciplinary problem which needs correction. Therefore, the employee must have a meaningful opportunity to challenge those "lesser" actions as they may become the substantive basis for later penalties. If the employee is denied due process on the lesser actions in the chain, she could be precluded from challenging their effect on more substantive actions, such as a discharge action.

Although a written reprimand does not carry the same immediacy as a discharge for an employee, the issue of truth exist for both serious and minor infractions. It must first be established there has been an infraction and then a fair penalty imposed after proof is determined. The VA has recognized the employees legal interests in statute and must consider what revisions could lessen administrative time burdens but preserve employee due process." We believe Section 224 addresses our previous concerns.

ANA supports the provisions of S. 573, S. 748, and S. 574, S. 899, and S. 900.

S. 947 - "Veterans Health Care Personnel Act of 1989"

Recently INA local unit representatives from Hines VA Hospital, Hines, Illinois, and Westside VA Hospital, Chicago, met with Secretary Derwinski to express their views about the impact of the nursing shortage on patient care in VA hospitals. In the last year, nurses in INA-represented facilities have become increasingly concerned about dangerously low levels of professional nursing staff and deteriorating patient care.

A staff nurse in psychiatry for 16 years at Hines VA, expressed the feelings of the VA nurses present when she said, "We stay in the VA system because we care for and respect the veterans patient. We think that the VA has excellent programs and the potential to give the best care. But nurses in the community are afraid to transfer their patients to our hospitals because they believe we have a reputation for poor patient care."

Nurses who are employed at Westside, discussed other concerns related to staffing and compromised patient care. They gave statistics demonstrating the low ratio of RNs to patients at her work place and discussed poor working conditions that make it difficult to retain nurses.

They discussed the effect of staff shortages on basic patient safety procedures. "We have to live with ethical dilemmas and terrible choices about patient care when there is one nurse for 40 sick patients." In discussing autonomy of nursing at VA facilities, they stated "we have a good relationship with nursing service at Hines." But nursing service must have authority equal to other departments in the VA hierarchy for us to function as true professionals."

We urged Derwinski to ~~implement~~ the recommendations of the federal Commission on Nursing and to set up a task force reporting to him directly to resolve the nursing shortage in VA facilities.

Years ago, VA hospitals were in the forefront with respect to nurses' salaries, benefits, and educational and professional development. However, as the private sector responded to changes in reimbursement, patient acuity, and health care manpower concerns, the VA has been unable to compete. The private sector can respord to market demands faster than the VA which is subject to the appropriations process and budget restrictions. Nowhere is that more evident than in nursing recruitment and retention. In Pennsylvania, for example, we are told that VA hospitals have no budget money for recruiting nurses. In fact, the nurses themselves, experiencing the impact of the nursing shortage on their patient care, have funded recruitment events.

We are concerned that where the VA once led the way in research and innovative clinical programs, budget reductions will impede the development of new care approaches. It is especially important that the VA's advances in geriatric care and gerontological research and education not be curtailed. Additionally, as the numbers of aged veterans and those requiring long term care (patients with head injuries and HIV infection) increase, we must have adequate nursing homes and manpower to provide quality health care. Nurses who participate in VA funded research grant programs report an inability to get basic resources such as desks.

As a result of FY 89 budget restrictions, we have already seen veterans' access to health care adversely impacted. Many VAs have closed beds and units due to the inability to supply nurses; other VAs are examining their specific mission which may limit veteran access. Additionally, clinics in Chicago have been told to discharge stable patients and only service-connected patients can be followed indefinitely. Community follow-up is questionable.

Budgetary reductions have also resulted in a reduction in nurse mix in several VA medical centers; in some, a 50 percent correction (staff reduction) has been ordered. Nurses from Illinois and California VA hospitals report freezes in employment of RNs, licensed practical nurses (LPNs), and licensed vocational nurses (LVNs). The Illinois Nurses Association reports that one VA hospital has 20 nurses on waiting lists for hire because the hospital cannot foresee a ceiling for RNs because of budget uncertainties. In Region 6, several hospitals, including Livermore and Reno, reduced their RN ceiling in FY 88 in anticipation of the FY 89 budget restrictions. How can we justify hiring freezes on VA nursing personnel and reductions in nurse mix, when there is an extreme nursing shortage within the system?

The freeze has also meant that in Illinois' Westside clinic, RNs were rotated to the emergency room with no orientation, even though many of them did not have the requisite skills for emergency care duty. Similarly, medical-surgical RNs in the Martinsburg, West Virginia facility have to float to oncology units without sufficient orientation. In one California facility, the position of the infection surveillance coordinator has been reduced to a 0.5 full time employee equivalent (FTEE) level, and the coordinator must share evening administrative nurse on-call duties. This is occurring while private sector infection control practitioners are reporting an increase in their workloads in response to the development, implementation, and compliance with occupational health standards for blood-borne diseases such as hepatitis B and HIV infection.

Nurse managers have been instructed to increase non-RN staff to make up for RN reductions. However, VA medical centers report high LPN/LVN vacancies and turnovers, and reductions in LPN/LVN ceilings. The VA cannot employ adequate numbers of LPNs/LVNs because they cannot compete with the private sector. This decrease in RN mix also means that the VA will have to utilize increasing numbers of lower skilled employees to provide health care to veterans. It may also mean that veterans may be deprived of essential life-preserving care and treatment. In North Chicago, the Illinois Nurses Association reports that if the chemotherapy nurse is on leave or ill, there is no replacement; therefore, no chemotherapy is provided.

The operating room nurses in the Martinsburg's VA are required to float to the medical-surgical units. The Lexington, Kentucky VA has had two nurse anesthetist vacancies for some time. Both these situations may limit scheduling of surgeries for veterans.

The proposed budget will provide no funding for the revision of RN pay scales. As pointed out in the document "The Need is Now", $400 million must be appropriated to maintain the same level of RN staffing in FY 90. Those funds must be provided in full and up front, in order to eliminate the occurrence of serious shortfalls. Previous shortfalls have resulted in staff cutbacks and corresponding reductions in needed services for veterans.

Existing shortfalls will result in a reduction of more than 100 RNs in the northeast region. Those numbers do not include nursing assistants, whose cuts could be equal to or more than the RN cuts. The mid-atlantic region has been instructed to reduce RN ceilings by 76 and LPN/nursing assistants by 25. Those facilities that have not reduced their staff will be required to do so in the future. Additionally, reductions in clerical, pharmacy, and respiratory therapy positions will mean additional duties for RNs.

Nursing staff and support salaries must be increased; at least 3,000 beds are closed due to nursing shortages. The VAs in Cincinnati, and Louisville and Lexington, Kentucky have hired nurse recruiters to combat the nursing shortage. The VA no longer leads the way with benefits such as salaries or retirement packages. Nor has the VA been able to supply the necessary computer assistance for nursing, as many hospitals in the private sector are doing.

Decreases have occurred in funds for education programs. Nurses across the country complain that they cannot attend continuing education programs because the hospital cannot spare them for a day, even when they personally fund the classes and request annual leave as opposed to administrative leave. VA nurses will not be able to acquire new skills or maintain skills if such practices continue. Additionally, nurses may not be able to meet state licensure requirements for continuing education.

ANA supports the intent of S. 947 which is to assure VA competitiveness with health care facilities. However, we do have concerns regarding the administration of the program as written.

We recognize that directors of VA health care facilities need the same flexibility that private sector health care administrators have to recruit and retain from a limited pool of qualified registered nurses. Surveys of basic pays are one way to determine the necessity for pay adjustments. Such surveys must reflect specific criteria and be based on reliable methodologies to assure consistency throughout the VA system. Comparisons with surrounding or similar labor markets must take into account reports that facilities may under represent their actual compensation levels to maintain their competitiveness.

We believe that such surveys and adjustments should occur at least yearly after the effective date of Section 4107A. ANA is pleased to see that reduced rates of basic pay shall not apply to employees before the effective date of the reduction as long as they continue service in that position at the same facility. Additionally, we applaud the continued application of bonuses for employees as outlined in under Section 4120.

We are concerned that the requirements for Department issued regulations permit the issuance of interim regulations without establishing a deadline for final issuance of such regulations. The language appears to allow the directors to make determinations and implement rates of basic pay in the regulatory void which will exist until final regulations are issued. We believe that the Department must be given a specific date of compliance for issuance of final regulations.

Although the Department reporting requirements to the Committee are extensive, we question the admonishment of documentation requirements in the proscribed regulations. We are also concerned that the bill does not appear to provide requirements for employee or employee representative participation in the survey process or regulatory development.

As we have indicated in past testimonies, ANA supports the lifting of caps on overtime pay for nurses and the additional pay for head nurses provided in Sections 102 and 103, respectively. The expansion of the waiver of reduction in retired or retainer pay for registered nurses is also welcomed by ANA.

Additionally, we support Section 106 which provides additional payments upon a nurses recertification. ANA supports certification as a professional advancement tool and a quality assurance mechanism. If the VA provides financial recognition of the professional benefit and quality assurance for patient care inherent in certification, VA nurses should be encouraged by personnel policies that facilitate administrative leave for continuing education and certification.

ANA recognizes that cash awards are a well established personnel policy for the federal government and appreciates the need to clarify head nurses as supervisors. However, cash awards must not be used to substitute for more appropriate restructuring of compensation levels. This is especially true when the problem intended to be addressed by the award is the structure of a professional group and not an individual merit application for outstanding service.

We understand that Section 301 which addresses the health scholarship program is intended to assist in earlier availability of a nurse. However, we believe that applicants are often lost because of financial need before the final year of education. Therefore, earlier assistance may be a better recruitment approach. Although, we recognize the necessity of equitable allocation of scholarships to associate degree candidates, we would urge the Department to encourage applicants to pursue the education course of most demand. The federal government predicts that by 1990, the demand for baccalaureate-prepared nurses will exceed the supply by 340 percent. The projected shortfalls by the year 2000 will be even greater. If these projections come to pass, it is obvious that a critical shortfall in such prepared registered nurses will be upon us before the next century.

ANA remains concerned about the development of new health careers outlined in Section 302. We would reiterate our testimony of September 7, 1988, we are especially concerned that new health careers is seen by some as an answer to the nursing shortage. Introducing a new breed of health worker will only create more confusion, as well as accountability and liability problems, without addressing the real need, which is improved compensation and better support systems for nurses. Nurses, who best understand their practice settings, must be centrally involved in defining and developing those systems.

The VA presently uses nursing assistants and licensed practical nurses to assist the registered nurse in providing care to patients. The utilization of support staff has meant delegating nursing care functions. Additionally, some treatment functions previously administered by nurses have been assumed by technicians. Therefore, we supported increased use of nursing assistants and LPNs. Increased compensation and premium pay must be provided for these critical personnel as well.

Differentiating between levels of practice for the purpose of better utilizing nursing personnel is a very sound management principle. Moreover, changes in health care are requiring more of nurses, which the profession has both anticipated and responded to in setting new standards for practice. The nursing shortage is caused in large part by the surging demand for nurses who possess the versatility, organizational ability, and breadth of clinical knowledge and judgment to operate in today's fast-paced, high acuity, and complex health care environment. The VA needs such professionals to assure quality care to our veterans.

In closing, we thank the Committee for addressing a myriad of health care and personnel policies early in this session. We applaud your support of nurses' rights and protections under collective bargaining as originally legislated and the reiteration of the Committee's intent regarding Title 38 employees.

We hope that these hearings help to maintain the ability of the VA to provide quality health care. Thank you again for the opportunity to present our concerns and recommendations.

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BEFORE THE

U.S. SENATE COMMITTEE ON VETERANS AFFAIRS

MAY 18, 1989

Mr. Chairman and Members of the Committee, I am Claudette Morrissey, a Registered Nurse employed full-time as a Staff Nurse on the evening shift in a surgical intensive care step-down unit at the Veterans Administration Medical Center, Brooklyn, New York. I am here today speaking as the President of the Nurses Organization of the VA (NOVA). NOVA thanks you, Mr. Chairman, for your long history of commitment to our nation's veterans and the veteran health-care system established to serve them. NOVA is speaking today for the nurses who continue to stay and care for veteran patients in spite of staff shortages, budget shortfalls, and difficulties recruiting and retaining health care personnel. We are loyal and dedicated employees who pull together in difficult times, who like taking pride in what we do and dislike seeing VA attacked and criticized from without. We are resentful when non-VA nursing colleagues indicate they think VA is a second-class place to work or assume that if you can't work elsewhere, you can always work at VA. We have glimpses from time to time of how great VA health-care system can be and take pride in the system's accomplishments. On behalf of these nurses, I wish to thank you, Mr. Chairman, for inviting us here today and for having heard us when we appeared before you in the past. The legislation before us today is a demonstration of your understanding of our past statements and your commitment to the future of veteran health care.

The ability to recruit and retain adequate numbers of registered nurses and other health-care professionals is crucial to the VA mission of providing quality care to the veteran patient. When there are not enough nurses, patient care is severely compromised and patients do not get the care they require. Nurses work with the fear that we will make a life-threatening mistake, or that we will not be available to observe when a patient's condition changes for the worse.

VA studies have pointed the way to the solution. The 1981 study of nurse recruitment and retention mandated by PL96-330 recommended that pay rates be competitive with the community rates. VA's December 1986 survey data on private pay comparison was alarming when only 54% of VA facilities reported that salaries were comparable to those in the private sector. Additionally, 50% of the facilities reported that regularly scheduled general pay increases at other medical facilities place them at a disadvantage in hiring and retaining registered nurses and that 40% of those who declined employment gave salary as the reason.

The study of the Commission appointed by the Secretary of Health and Human Services published in December, 1988 proposed over 80 directed strategies in the areas of (1) utilization of nursing resources by focusing nurses' time on nursing responsibilities, (2) nurse compensation, (3) health-care financing, (4) nurse decision-making, (5) development of nursing resources through facilitating nurse education, and (6) maintenance of nursing resources.

The legislation before us today addresses particularly the area of nurse compensation. NOVA is pleased to bring the perspectives of working VA nurses to this hearing, and will comment on the appropriate sections of the proposed legislation.

S947
TITLE I
Pay Matters

Section 101
Pay rates for Nurses and Other Health-Care Professionals in Certain Positions

NOVA strongly supports the purpose of this section, which is to ensure that VA health-care facilities are competitive on the basis of pay and other employee benefits in the recruitment and retention of qualified personnel for such positions. NOVA also endorses the proactive spirit of this legislation which mandates that an annual wage survey be done and that salaries are adjusted to be competitive before there is a recruitment or retention crisis, unlike the reactive way special salary rates are currently handled. NOVA is very pleased to hear that it is your intent that the determination of competitive pay by the facility director would be made with the input of the individual chief nurse. We also applaud the effort to avoid salary compression within grades and steps or between grades by requiring that the grades and steps established maintain the same proportional distribution between steps and grades that currently exists.

NOVA appreciates the intention of the committee that changes the salary scale for nurses so as to be competitive with, but not exceed, the wage rate paid in a given community and that it not contribute further to the inflation of health care costs. But it is clear from recent surveys of national nurse salaries that the current VA entry level salary of $17,542 is well below the lowest average salary of $18,477 paid in March 1987 in the West North Central US, according to the American Nurses' Association. It is for this reason that NOVA recommends that the VA nurse entry-level GS 6 be the base below which the salaries would not be decreased. NOVA also suggests that starting the first annual survey in June 1990 and keeping the annual salary survey in December of subsequent years would allow the Cost of Living Adjustment of the previous January to make salaries competitive and forestall the need to adjust the salary scale.

Section 102
Overtime Rates of Pay for Certain Nurses

NOVA is particularly gratified to see that this legislation addresses the issue of the cap on overtime pay. The issue of the cap on overtime rate is one that our members have brought to our attention frequently. It seemed to defy their belief in common sense and fair play, particularly in the facilities with special rates where it was not uncommon for nurses to make less at the overtime rate than the regular hourly rate. The overtime rate has been so unfair that nurses either resist working overtime, or are given compensatory time off when they do work overtime. This process conceals the amount of overtime that is needed to staff the hospitals, and contributes to a continual shortage of staff available to care for patients if nurses take the comp time to which they are entitled.

Section 103
Additional Pay for Head Nurses

The position of first line manager, or head nurse, is crucial in any hospital organization. The head nurse is responsible for the unit or ward where the majority of direct patient care is provided. The responsibilities of this position have increased greatly as our hospitals have increasingly decentralized responsibilities to the unit level. There is presently no financial incentive to assume this management role. For this reason, NOVA supports the provision of a six percent pay differential for nurses appointed to the head nurse position.

Section 104
Waiver of Reduction in Retired or Retainer Pay for Registered Nurses

When NOVA appeared before you this past June, we encouraged the support of the authority for VA to hire retired military nurses without retired nurses losing their military retired pay. NOVA believes that retired military nurses may be a source of highly qualified nurses for VA as well as a source of nurses who are familiar and comfortable with our patients and the federal heath-care environment.

Section 105
Special Rates of Pay

While it is hoped that the implementation of competitive pay would greatly reduce the reliance on special pay, the opportunity to increase the present limit is welcomed and the requirement to notify this committee when salaries come within 94 percent of the maximum rate should prevent the current situation from occurring in the future, NOVA supports the reduction in time allowed for approval of special rates.

Section 106
Consideration of Professional Specialty Certification

NOVA is pleased to see the recognition of nurses for specialty recertification with a lump sum payment of one percent upon recertification, provided that the nurse's last proficiency was not less than satisfactory.

TITLE II
Other Personnel Benefits

These sections include some exciting new provisions in the form of exemplary performance cash rewards for professional supervisors and managers, leave transfers and leave banks, as well as the dependent care assistance program. NOVA commends you for these creative provisions. The dependent health care provision is particularly exciting because many VA nurses have responsibilities for minor children, dependent spouses, or others. Benefits in these areas will make VA a more attractive place to work.

TITLE III
Health Care Education

Section 301
Health Professional Scholarship Program Awards

NOVA appreciates the committee's recommendation that the Health Professional Scholarship Program be made available to nursing students enrolled in an associate degree program. Financial assistance from VA for this group is an incentive for recruitment into practice at VA medical facilities as well as an incentive for career development and retention within the VA health-care system.

Section 302
Assistance to Health-Personnel Educational Institutions

NOVA endorses the concept of this proposal. The schools of nursing need the support to develop innovative programs that will reach out to corpsman, paramedics, and others with health-care training and no clear career path to pursue a nursing education. We hope this can be done in conjunction with employment at VA. Seriously ill veterans are in need of nursing care, care that is complicated by factors of age, chronic illness, multi-system involvement, high-tech treatments, and the pressure for early discharge from hospitals. The need for this level of nursing care frequently continues after acute care into long-term care facilities and the home. The patient acuity mandates that nurses be at the bedside. Since nursing's major occupation has always been, and will continue to be, providing nursing care at the bedside, NOVA supports this effort to increase the numbers of nurses with innovative programs. NOVA also supports the efforts to increase the supply of other scarce health professionals and established health occupations. NOVA cautions against the establishment of additional levels of health care workers under the provision of "development of new health careers." NOVA agrees with our nursing colleagues outside VA that new categories of health care technicians are "unnecessary, duplicative, and costly, and can only serve to further fragment patient care."

TITLE IV
Other Personnel Management Matters

Section 401
Employment of Personnel Trained by the Department of Veterans' Affairs

When fewer than six percent of students who received their training and clinical experience at VA facilities take their jobs at those facilities, VA may very well be missing an opportunity to hire health-care workers. The waiver of the usual civil service hiring process may or may not increase the percentage hired. Students who affiliate are looking over the VA system just as VA has the opportunity to observe them. Student nurses who affiliated with VA have frequently stated that they did not choose to seek employment at VA because "VA nurses work too hard." NOVA does not oppose the waiver of the civil service hiring process, but we believe the key to attracting and hiring VA-trained graduates will be the creation of a favorable work environment.

Section 402
Pilot Program of Pay and Personnel Management Practices

1) NOVA supports the establishment of pilot programs.

2) Collaborative Practice Programs

NOVA is pleased to see this issue addressed. At a meeting of the Health and Human

Services Secretary's Commission on Nursing, Elizabeth Draper, RN, of Apache Medical Systems, presented her study which showed that closed collaboration of RN's and physicians makes a difference in the outcome of fewer than expected deaths.

NOVA has, in the past, testified that this collaboration would improve professional and job satisfaction for nurses and welcomes this confirmation that it is also good for the patient.

3) Creating New Nursing Models for Furnishing Care

NOVA thanks you, Mr. Chairman, for your confidence in nursing within VA. The opportunity to create new models for delivering patient care may help VA nursing assume its rightful place in the development of innovative practice models.

4) Pay Differentials

The rotation of shifts has long been one of the more onerous aspects of working as a nurse. Large enough economic incentives have not been tried to attract sufficient numbers of volunteers to work unpopular shifts as is done in other 24-hour-a-day industries.

VA nurses have indicated in past studies that this is a big issue for them. NOVA thanks you for including this pilot project and hopes VA will act quickly to utilize the authority they have in place.

5) Revision of Appropriate Personnel Management Systems

NOVA endorses pilot programs that address problems in recruitment and retention. Issues of pay compression and non-competitive, flexible benefits are frequently given as reasons for leaving VA nursing, or for not coming to VA nursing.

Extension of Authority to Furnish Respite Care

NOVA members who have had experience with respite programs have requested that NOVA strongly support the extension of the authority to provide this care to chronically ill veterans. Respite care has been an innovative and successful program and VA nurses believe it deserves continued support.

Section 8
Pay Enhancements for Department of Veterans Affairs Nursing Assistants and Nurses

(a) Premium Pay for Certain Nursing Assistants

NOVA supports the authorization of premium pay for nursing assistants.

In summary, Mr. Chairman, NOVA commends the provisions in this bill and believes it is a positive move toward making VA more attractive and competitive with the private sector in the recruitment and retention of nurses. NOVA thanks the Committee's continual commitment in addressing the nursing shortage, its effect on patient care, and nursing's vital role in the VA mission to provide quality health care. Recruitment and retention of registered nurses in the VA system is imperative, for not only do RN's provide health care services of demonstrated quality more cost effectively than any other health care given, RN's are the front-line health professionals who can properly deliver and coordinate the health-care and recovery process of veteran patients.

Therefore, NOVA asks the support of all the Members of this Committee to approve the approaches reflected in S947 and to assure that this legislation will be accompanied by an appropriation request that will make it possible for directors of medical centers to carry out the recommendations. We thank you, Mr. Chairman, for the opportunity to appear before you today. We pledge to continue working with Congress and VA to assure that veterans receive the care they need and deserve.

I will now be happy to answer any questions.

STATEMENT

BY

ARTE J. PIERCE
PRESIDENT
NATIONAL VETERANS' ADMINISTRATION COUNCIL

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES,
(AFL-CIO)

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ON

S. 13, S. 573, S. 574, S. 748, S. 947
and other proposals pertaining to the
Department of Veterans' Affairs

May 18, 1989

Mr. Chairman, members of the Committee, my name is Arte J. Pierce. I am President of Council 53, the National VA Council of the American Federation of Government Employees, AFL-CIO (AFGE). AFGE represents more than 50 percent of the Department of Veterans' Affairs, (DVA), workers who are in bargaining units at DVA. They include both professional and nonprofessional, medical and medical support personnel. For this reason, we have intimate knowledge of the cares and concerns of those employees and are in a unique position to discuss them with this Committee.

The subject of this hearing, to address some of the critical problems faced by the DVA particularly in the area of the recruitment and retention of nurses, nursing assistants and medical support personnel, could not be more timely. We commend the Committee for recognizing the immediate need to address these problems and other health care measures if the DVA's mission of providing quality care to veterans is to be achieved. As you requested, we will confine our remarks to our overall views on the impact of the _Colorado Nurses_ decision and to the efficacy of the proposed recruitment and retention legislation in addressing the severe shortage of certain health care personnel.

On July 19, 1988 the United States Court of Appeals for the District of Columbia rendered its decision in the case of _Colorado Nurses Association v. FLRA_. That decision had a devastating impact on employee morale and reversed an historical trend. In a nutshell, the Court determined that Title 38 establishes an "entirely different personnel system from that embodied in Title 5" which gives the "Administrator unfettered discretion to issue regulations concerning working conditions." On this premise, the Court concluded that although the Administrator may choose to bargain over matters affecting working conditions, he has absolutely no obligation to do so. Quite simply, the Court found that Title 38 "leaves no room for mandatory collective bargaining."

The background of this matter had its beginning in 1946 when Congress established the Department of Medicine and Surgery, (DM&S), of the Veterans Administration. DM&S was given the special mission to care for this nation's wounded and sick veterans. In so doing, Congress gave to the Administrator broad authority and discretion over the DM&S medical personnel and their working conditions. The intent of the Congress in giving him this unusual grant of authority was to enable the Administrator to staff VA medical facilities with competent personnel in a timely manner, unhindered by the cumbersome and lengthy processes endemic to the civil service system. Further, it was believed that the normal civil service channels could not appropriately address disciplinary matters stemming from claims of medical malfeasance or incompetence. Thus, the language of Section 4110 of Title 38, which is an amplification of the Administrator's broad discretion over working conditions embodied in the language of Section 4108, mandates the use of so-called peer review boards for all disciplinary matters.

Throughout the early years of DM&S, labor-management relations were good. Employees were well represented and morale was high. Notwithstanding the general authority given to the Administrator in Title 38, he negotiated with exclusive representatives over conditions of employment for both Title 5 and Title 38 employees. This practice became mandated for the Title 5 employees and was believed to be mandated for Title 38 employees after the passage of the Civil Service Reform Act in 1978. Hence, it was continued at the VA. Although there were cases which involved the scope of negotiability over working conditions, it was generally recognized that the Administrator had the same duty to bargain over working conditions for Title 38 employees as it and all other agencies had with respect to Title 5 employees except with respect to the disciplinary boards.

Pursuant to such negotiations, collective bargaining agreements were entered into between the VA and the unions who represented both groups of DVA personnel. The one major difference in the negotiations affecting both groups was the fact that Title 38 employees were unable to negotiate a grievance procedure to be utilized in the case of disciplinary matters. Instead, those employees were subjected to the disciplinary boards established pursuant to Section 4110 of Title 38 for all disciplinary matters.

As pointed out above, this situation was radically changed by the decision in Colorado Nurses. The Court found that the Civil Service Reform Act did not override Section 4108 enacted some 34 years earlier. The Court said that the Secretary does not have to negotiate over the working conditions for the Title

38 employees as he and the head of every other department within the Executive Branch, must for Title 5 employees. Title 38 and Title 5 employees working side by side at the DVA are now treated differently. They now have different rights for which we see no valid reason.

Congress has consistently maintained that collective bargaining is in the public interest. This was specifically expressed in the language of Chapter 71 of Title 5, the labor-management provisions of the Civil Service Reform Act. Therefore, to the extent that collective bargaining is not inconsistent with the intent of the specific provisions of Title 38, e.g. the use of disciplinary boards for matters involving serious disciplinary actions with respect to medical competency, the collective bergaining provisions of Chapter 71, Title 5 should be applicable to those employees covered by the provisions of Title 38. But in order to achieve this, it is now necessary that there be an appropriate "legislative fix".

S. 13 provides just such a solution and we were especially pleased by the Chairman's swift action at the beginning of this Congress in introducing S. 13. S. 13 is a bill to "amend Title 38 to increase the rates of disability compensation and dependency and indemnity compensation for veterans and survivors, to increase the allowances paid to disabled veterans pursuing rehabilitation programs and to the dependents and survivors of certain disabled veterans pursuing programs of education, and to improve various programs of benefits and health-care services for veterans, and for other purposes."

It is the provisions which provide for "other purposes" that will provide the necessary "legislative fix" and the ones in which AFGE has a direct interest. Specifically, Section 223, which pertains to collective bargaining agreements, and Section 224, which pertains to disciplinary actions and grievances. AFGE also is interested in and supports Section 221 relating to DVA security services which affects directly some of AFGE's members.

Section 223 amends section 4108 pertaining to the Secretary's authority to establish working conditions. The language utilized makes it patently clear that the provisions of chapter 71 of title 5 shall apply to the exercise of the Secretary's authority. This language, coupled with the clearly expressed intent of Congress, would negate the result reached in Colorado Nurses and would insure that the DVA must negotiate over working conditions in the same manner as all other agencies. The result of this would be that all employees of the Executive Branch including the Title 38 DM&S personnel, would have the same labor-management rights. No longer would DVA Title 38 employees have fewer rights than the DVA Title 5 employees working right next to them. On the other hand, S. 13 does not strip the Secretary of all of the authority he now has under Section 4108. The mandate that the provisions of Chapter 71 of Title 5 are applicable to Title 38 personnel, or this proposed restriction on the Secretary's authority, is subject to several exceptions.

Specifically, the Secretary does not have to bargain over any of the specific areas set forth in Section 4108 with respect to employees: (1) assuming care of patients other than at a VA facility; (2) teaching or providing consultative services if such will conflict with his VA position; (3) accepting payments for professional services rendered, per diem or travel reimbursement, or malpractice insurance coverage from outside sources; or, (4) charging a fee for the performance of services in the course of VA employment. In addition, the utilization of a negotiated grievance procedure for disciplinary matters is limited.

Section 224 specifically addresses negotiated grievance procedures and is identical to the provision which the VA agreed to last year and which was included in legislation passed by the Senate but deleted in Conference. It would permit the use of a negotiated grievance procedure with respect to Title 38 employees in all cases where the proposed action is a suspension for 14 days or less, reassignment without a reduction in basic pay, reduction in rank with a reduction in basic pay, reprimand, or admonishment.

In essence, S. 13 preserves the intent behind the enactment of the special Title 38 personnel system. That intent was to provide the Secretary with sufficient authority to determine the competency of medical personnel whether it be for purposes of recruitment or for disciplinary matters. In other words, the uniqueness of the DVA mission and the need for the specialized skills which must be possessed and utilized by the DVA medical personnel appeared to mandate procedures outside of the normal civil service regime. Thus, unfettered authority was given to the Secretary. S. 13 would retain that authority as it pertains to medical issues. And while we believe that all disciplinary matters could be handled via negotiated grievance procedures to the advantage of both DVA and to the employees, we believe S. 13 is a valid compromise. It mandates collective bargaining under the provisions of Title 5 for all Title 38 employees. In addition, it provides for the use of a negotiated grievance procedure, instead of the disciplinary boards for the Title 38 personnel. At the same time, it leaves untouched those aspects of the Secretary's authority which are deemed vital to the efficacy of the Department. For these reasons, we wholeheartedly endorse and urge speedy consideration of Sections 223 and 224 of S. 13.

In addition to the above sections, Section 221 of S. 13 would require the Secretary to submit a report to Congress within 90 days detailing a plan for improving the training, recruitment and pay of VA security and law enforcement personnel as well as an assessment of the need for establishing, among other things, a policy on the issuance of weapons to such personnel.

Security at VA facilities and the safety and well-being of patients and employees is becoming a matter of increasing concern. Facilities in large metropolitan areas are particularly plagued by crimes or attempted criminal acts. In the last several years, there has been a significant increase in the number of incidents wherein DVA law enforcement and security personnel have been killed or injured or simply could not prevent criminal activity because they were inadequately trained or because they were unarmed. This jeopardizes the well-being and safety of patients and other employees. While Section 221 does not provide any tangible means towards solving or alleviating the problem because it is a so-called "study" provision, it does call attention to the fact that there is a problem. We hope the result of the study generated by Section 221 will prompt swift enactment of definitive measures which focus squarely on resolving the issue.

S. 947.

The other issue on which we wish to express our views is the very critical recruitment and retention problems now being experienced by virtually every VA medical facility in the country.

Health care personnel are unique. Their humanitarian and altruistic motives for entering the health care profession in the first place, forms a solid base for continued dedication and loyalty to patient care throughout their careers. This is particularly true of the present VA employees engaged in health care. The workers who have remained with the DVA despite staff shortages and budget cuts, are clear examples of such loyalty and dedication. These employees are faced with increasing workloads as vacancies remain unfilled. These employees work overtime despite overtime pay caps. These employees cannot be spared to participate in continuing education programs to acquire new skills or to maintain and improve skills already utilized; a situation which might lead to failures to meet state licensure requirements.

Why has the situation in the VA medical centers become so acute? The answer is two-fold. There is a national shortage of nursing personnel -- not just RN's, but LPN's, LVN's and support personnel. This means that all medical facilities, both public and private, face fierce competition in attracting sufficient staff to carry out their functions. DVA is simply not in the race. Years ago, VA hospitals were often thought of as showplaces. They were in the forefront in terms of medical research and model clinical programs. The special Title 38 pay provisions insured that the VA could compete because it could offer highly competitive salaries, benefits, and opportunities for professional development. As a result, it attracted some of the best medical personnel in the country. But, alas, it, and the rest of the Federal government, has simply failed to keep pace with the changes in the private sector not only in the areas of pay and benefits but in other areas as well. For instance, in 1974, Congress passed the Health Care Amendments to the National Labor Relations Act which gave all private sector health care employees the same bargaining rights and protections afforded other private sector employees. After Colorado Nurses, this was simply another area where DVA was not competitive.

S. 947 introduced by the Chairman just last week is intended to "improve conditions of employment for employees" of the DVA. Philosophically, it appears to be a measure intended to enable the DVA to once again be a contestant in the race for becoming a "preferred employer" rather than the employer of last resort.

Title I of S. 947 essentially eliminates the current method of setting pay for DM&S personnel by Executive Order. In addition, it eliminates the current 8 grades for nurse positions. Instead, the Chief Medical Director is to prescribe the number of grades and steps for all nurse positions. Entry level pay for all DM&S personnel will be determined on the basis of an annual survey conducted by the each Director of a DVA medical facility. The survey is to be of the entry level compensation for corresponding positions in a sufficient number of comparable facilities within a labor market area identified by each Director. Notwithstanding these provisions for setting entry level pay on the basis of a locality survey, the Secretary would retain the existing statutory authority to pay special recruitment and retention bonuses. The Secretary is directed to promulgate regulations pertaining to the conduct of the annual surveys but in the absence of such regulations, the surveys are to be conducted and the wages established anyway.

Title I would remove the cap on overtime pay for Title 38 nursing personnel. In other words, overtime at the rate of time-and-one-half the hourly rate would be paid for all hours in excess of 40 in an administrative work week or eight in any one day.

Under the provisions of Title I of S. 947, head nurses would receive a 6 percent increase in pay; would not be subject to the offset if their were receiving retirement or other pay from the U. S. Government simultaneously with their DVA salaries; and would receive a bonus for recertification of 1 percent of salary.

Title 2 of S. 947 provides for cash awards of from 5 to 20 percent of basic pay to be made to supervisors or managers, including head nurses, in accordance with regulations proscribed for the making of such awards. It mandates the establishment of a dependent care assistance program qualified under Section 129 of the Internal Revenue Code as well as a leave bank/transfer program similar to that provided under Chapter 63 of Title 5 for other civil service employees.

The provisions of Title 3 of the proposal makes certain amendments to the health care education provisions of Title 38 and the final Title of the bill contains two major sections. First, it gives the Secretary direct hiring authority without regard to the provisions of Chapter 33, title 5 and it mandates conduct of a pilot program for the purpose of studying and testing various pay and personnel management practices.

At the outset, we must point out that AFGE has consistently opposed alternative and special pay systems for certain groups of employees on the premise that this is disparate treatment of career employees. As it once testified before the Senate Committee on Government Affairs:

> If the Congress follows the path of trying to patch up every area of compensation as each area reaches a crisis stage, we will end up with a hodge-podge of hundreds of separate pay and personnel systems with no overall coherence. Such a gerrymandered pay system would be a nightmare to administer, would subvert the principle of equal pay for equal work, and likely would reduce employment mobility within the federal sector. We don't think the nation or federal employees would be served by such a result. We cannot advocate returning to the formative years of the civil service.

AFGE maintains that federal compensation should be based on the principles of full comparability with the private sector. In fact, it is; but the system we have has not been allowed to work and so all federal sector wages lag behind those in the private sector. Thus, the whole pay system needs to be fixed -- not just a part of it. For this reason, AFGE would normally oppose legislation such as S. 947 which focuses only on health care personnel and is only applicable to such personnel employed by the DVA. If this measure were enacted, it would mean that nurses employed by other agencies would not be compensated in the same manner. Notwithstanding this, however, AFGE recognizes that the majority of federal employees who are in the health care professions are employed by the DVA and that there is a major difference between DVA medical personnel and personnel in other agencies. This difference is that there is a national shortage of medical personnel so if DVA is not competitive, it simply will not be able to fill vacancies. In the case of other employees, there may not be a national shortage in a given field. Thus, agencies can fill vacancies in those fields but its failure to be competitive means that only those who are not hired by the competitive employers, those who may not be the best and brightest applicants, will apply for government jobs. In other words, the government is the employer of last resort.

The national shortage of nursing personnel results in:

** DVA being unable to fill vacancies

** Unfilled vacancies forces the closure of entire wards of VA medical centers

** Closing entire wards at VA medical centers means that quality care for veterans is not readily available

** Lack of quality care for veterans is indicative that DVA is failing to perform its mission.

The only way to solve these problems is for DVA to be able to attract and retain nurses and other medical support personnel from the small pool of available applicants. It must be able to offer a competitive salary and it must provide a quality work environment. For these reasons, and because AFGE is totally committed to being able to provide quality care for veterans, AFGE, endorses the goal of S. 979, to enable DVA to attract and retain competent medical and medical support personnel, being considered by this Committee. However, we have grave concerns about the methods proposed in the bill in its present form.

We are especially concerned about the level of discretion granted to the directors of DVA facilities and the total absence of provisions which recognize and promote recognition of exclusive representatives and bargaining as a necessary ingredient in addressing the problems focused on in this bill. This bill opens the door to fundamental shifts in pay setting procedures. It is our belief that collective bargaining over all conditions of employment, including pay and benefits, is not only the fairest method of resolving these issues, but provides an effective systems of checks and balances so that the interests of all parties are well represented. However, until statutory provisions make possible full scope bargaining, it is our desire to work with the Congress and the agencies on reasonable alternatives.

One such alternative, is of course, the establishment of pay based on regional surveys. We are deeply concerned however, about the lack of specificity provided in this bill pertaining to the survey process. The parameters are vague and thus, the process could well result in approximately 172 variations subject to the subjective whims of each DVA medical facility director. It would be more reasonable to provide that the exclusive representatives at each union would have the right to bargain over the parameters of the local labor market area to be surveyed as well as over the positions included therein. At a very minimum, such parameters should be clearly defined and established by a neutral entity. For instance, standard metropolitan statistical areas could be utilized or the same areas that are presently utilized for blue collar pay could be adapted, including the provision for setting base-line pay where there is an insufficient number of comparable positions within the survey area.

The various provisions in S. 947 which provide for bonus pay for head nurses and managers and supervisors also raise concerns. In order for VA medical facilities to be fully operational, they must have a full complement of personnel. Besides doctors, anesthesiologists, radiologists and other technicians, such personnel is a mix of RN's (registered nurses), LPN's (licensed practical nurses), LVN's (licensed vocational nurses), nursing assistants, clericals, orderlies, pharmacy and respiratory therapy positions. And from this mix, a few must be managers and supervisors, e.g. head nurses, and the rest function in staff or line positions. The shortage in medical personnel exists throughout this mix and, of course, includes nurse managers and other supervisors as well as all other medical personnel staff. To address the recruitment and retention problems by providing incentives and bonuses for only a part of this mix, as S. 979 does, is, therefore, inequitable. The recommendation applies to managers and supervisors only and thus, is a short-sighted way to address part of the pay problems of just a part of the staffing mix. In addition, these provisions are not meaningful unless they are adequately funded through the appropriations process. We believe this would be unlikely in the near future. On the other hand, an across-the-board upward adjustment in the DVA pay schedule would benefit not only all VA medical personnel but would almost certainly be funded as Congress appropriates monies for VA basic salaries and benefits. There is absolutely no reason why the staff support personnel directly involved in patient care should be treated any differently from RN's. An across-the-board increase in basic pay would eliminate such an inequity.

We endorse the provision for eliminating caps on overtime pay. The small dollar savings achieved by capping overtime pay is totally negated when the critical recruitment problem is exacerbated because personnel know that if they work overtime at the VA they will not get the normal full-time and a half. Further, it makes absolutely no sense to provide compensatory time in lieu of overtime pay. The use of compensatory time simply means that fewer staff are available to provide patient care which again, only exacerbates a critical problem.

Title IV, as mentioned upon, provides for the establishment of a pilot or demonstration project in order to explore various pay and personnel management practices at various DVA medical facilities. AFGE was a strong advocate of the demonstration project authority contained in the Civil Services Reform Act which was designed to explore methods which could lead to better overall public administration. This authority, however, mandates the involvement of employees and exclusive representatives. Specifically, the statute mandates consultation and negotiation with exclusive representatives over the design and implementation of all projects. Further, no project can be implemented which would violate a collective bargaining agreement. Unfortunately, there are no similar provisions contained in S. 947. Not only is this patently unfair but it is inconsistent with the intent of S. 13 which provides for the applicability of the Title 5 bargaining rights to Title 38 personnel. Furthermore, since the intent of S. 947 is to enable the DVA to become a competitive in the race for the scarce medical personnel resources, the involvement of labor organizations in the design and implementation of pilot projects is imperative since full scale bargaining is now the norm and enjoyed by must such medical personnel in the private sector.

In summary, Mr. Chairman, S. 13 and S. 947 are clear recognitions of the serious problem faced by the VA -- a critical shortage of RN's, LPN's, LVN's, nursing assistants and support personal due in large part because of the inadequacy of the DVA to compete for applicants from the small pool available due to the national shortage of such personnel. This inability to compete stems from depressed pay and a lack of labor-management rights enjoyed by other federal and nonfederal employees. Sections 223 and 24 of S. 13 address the labor-management problems but providing that Title 38 employees should be on the same footing as all other federal employees. S. 947 focuses on the pay aspects of the recruitment and retention problems but as pointed out herein, we believe the measure leaves the door open to subjectivity and unfairness. Further, the absence of a definitive role for exclusive representatives in the overall schematic is an inexcusable void. Many of our concerns, however, could be overcome by amendments which would insure that a methodology for establishing pay for DVA personnel is based an clearly articulated, objective criteria and by insuring that labor organizations have meaningful input into that process, as well as into the design and implementation of any pilot or demonstration project.

We appreciate the opportunity to come before this Committee and present AFGE's views with respect to the various aspects of these bills addressing some of the problems faced by VA medical facilities. We hope that our comments and suggestions will be useful to the Committee in continuing to focus attention on these problems and to find solutions which are equitable across the board. To that end, if we can be of assistance to the Committee in addressing these problems, we would welcome the opportunity to work closely with your staff.

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5/15/89

NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES
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TESTIMONY OF THE

NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES

TO THE

SENATE COMMITTEE ON VETERANS AFFAIRS

REGARDING

RECRUITMENT AND RETENTION OF

HEALTH CARE PROFESSIONALS

May 18, 1989

The National Association of Government Employees is an affilliate of the Service Employees International Union, the fifth largest union in the AFL-CIO. The NAGE represents approximately 15,000 VA employees in 17 medical centers throughout the U.S. Our membership includes the full range of medical professional and support personnel.

On behalf of our membership I'd like to express our appreciation for this opportunity to appear this morning to give testimony on section 211, 213-15 and section 222-25 of S-113, the Veterans Benefits and Health Care Act of 1989 and secondly, the Recruitment and Retention of VA Health Care Providers. Both of these bills are thoughtful and creative attempts to address the recruitment and retention shortages among certain groups of VA professionals.

It is not news that the VA is experiencing severe recruitment and retention problems. This problem is clearly demonstrated by the high turnover late among VA professionals. In 1986 the turnover rate for RN's in the VA was 16%, in 1987 it rose to 22%, and then to 26.5% in 1988. The LPN turnover rates have rose from 18.9% in 1986 to over 30% in 1987, and 35% in 1988. Thus in these two crucial professions the VA is virtually replacing the entire workforce every three to four years. The 50% increase in the turnover rate in just two years for RN's and the almost 100% increase for LPN's is dramatic evidence of how low morale, and compensation problems are effecting turnover. A turnover rate this high has a direct negative impact on the quality of patient care provided to our nation's veterans. In addition, turnover wastes valuable tax dollars since for each employee hired there is almost six weeks of unproductive orientation plus miscellaneous expenses attributable to hiring and training. The higher the turnover rate, of course, the more often these expeditures must be made.

In addition to the high turnover rate, the quality of patient care has been compromised by decisions made by the VA to reduce the number of FTE's nationwide. There has been a reduction of almost 650 RN's and almost 1000 LPN's from 1987 to 1989. Whether this decision represents an admission by the VA that it is unable to recruit sufficient numbers of health care workers or was made for budgetary reasons is unknown to us. What is clear, however is that staff shortages are causing morale problems among health care professionals that we represent and is compromising their ability to deliver health care services.

At the Coatesville VA for instance there are severe staff shortages among the RN's and LPN's. The hospital is authorized to have 123 LPN's, but has 49 vacant LPN slots, and 219 authorized RN slots with 42 vacancies. The hospital is filling substantial numbers of these vacancies by using nursing assistants. The hospital has 230 nursing assistants slots authorized, but actually employed 290 nursing assistants with 60 nursing assistants functioning as RN's and LPN's. Thus almost one quarter of the professional nursing slots at Coatesville are filled by nursing assistants working out of grade.

Even with these measures staffing is so short that management has been forced to institute several other extraordinary measures in an attempt to maintain service. Virtually every day staff is ordered to work mandatory overtime and even relatively compelling family committments do not excuse the nurses from overtime assignments. As a compromise, however it has become a standard practice to permit personnel on mandatory overtime without child care arrangements to bring their children to the nursing station until child care can be arranged. As Coatesville is one of VA's largest psychiatric hospitals, this arrangement must trouble many parents. In addition the local union is troubled by staffing patterns caused by shortages which leave one nursing assistant alone on a locked ward with patients considered dangerous. Staffing is so short that RN's are unable to give or receive a 24 hour report of what happened in the previous shift. Finally sick leave usage has incrased dramatically, undoubtedly due to the long hours of work and the difficulties experienced by workers in spending reasonable amounts of time with their families.

Coatesville is but one of many VA hospitals with severe shortages. At the West Roxbury VA the turnover rate in 1988 was 47% among professional staff. At the Bedford VA turnover and shortages caused the hospital to close the nursing home unit last year. Nurses there are frustrated by their inability to get weekends of and by the repeated demands for mandatory overtime. Staff shortages there recently resulted in an injury to a confused patient who wandered off the ward while the sole nurse minding the unit was in a different wing tending to her duties.

The proposed "Recruitment and Retention of VA Health Care Providers" pending before the Committee today seeks to address this problem by providing to the local hospital administrator great flexibility to set pay in accordance with local compensation, addresses certain inequities in the current special rate authority, allows RN's to receive a full time and one half payment for overtime, provides a differential for the head nurse, provides incentives for professional specialty certification, allows for the development of a dependant care tax deduction program and establishes certain demonstration projects to test differing methods of establishing pay and compensation including pilot programs testing pay for performance, cafeteria benefits and personnel management reform.

The NAGE applauds the chair for this concerted effort to improve pay and working conditions of VA professional employees and address the severe recruitement and retention problems. The vast majority of these employees are currently under special rate authority. There are many inequities in this special pay system which this bill addresses. Many hospital administrators hired employees at above the minimum step of the grade and then failed to increase the salaries of those experienced employees on staff who were performing the same duties. This created an inequitable and counterproductive situation where senior employees with years of experience were paid less than new hire employees with substantially less experience. Special pay rates applied in this manner exacerbated existing morale and retention problems. The legislation under consideration today would correct this situation by mandating that when special pay is accorded to new hires, then all workers in the position, including senior workers in the position, will have their salaries increased irrespective of their step in the grade. This is an important correction to major flaw in the law.

The legislation also takes needed steps to accelerate the process of granting special pay increases. Far too frequently the process for gaining approval of special pay increases is cumbersome and time consuming. This legislation streamlines the process and makes it more responsive to staffing needs and allows administrators to address recruitment problems before they become acute.

We also support provisions in the bill to provide RN's with time and one half for overtime hours. This benefit is commonly provided in the private sector and it's absence in the VA is an unnecessary impediment to fulfilling staffing needs.

The major change to the pay system for title 38 professionals under consideration today would be to grant broad discretion to the hospital administrator to establish pay in accordance with a local survey. The NAGE has some reservations about establishing a locality based pay system as our experience indicates that such systems creates morale problems.

We are also concerned about the broad disparities in pay which will arise under this system between title 38 and title 5 employees. With these changes the VA would pay health care professionals differently then DOD, NIH, HHS and other federal agencies do, and could result in competition between agencies for needed employees. The legislation also does not address the severe pay problems of many title 5 health care workers.

We also have a number of concerns about the mechanics of establishing the pay rate under the bill. There are few standards established for the pay survey and great discretion granted to the local VA hospitals. There are a variety of technical issues involved in doing such a survey, and we question whether the VA currently has the capability to do such surveys on a broad scale. To thrust this task upon the administrator without proper resources could be disasterous and to provide such resources could be quite expensive. Finally we note that there is no provision allowing for Union involvement in this pay setting process. We think this is extremely important particularly in light of the absence of clear cut standards for doing the local survey.

Recruitment and retention problems are being experienced across the board in virtually every federal agency. The problems causing turnover are not unique to the VA. Medical professionals like most groups of federal employees are angry at their treatment by their employees. Federal employees are angry about the repeated attacks on their pensions, their inadequate pay raises, and costly health insurance plans. Our organization believes that these problems should be addressed in a comprehensive manner and we are troubled by the consequences attributable to a piecemeal solution. We believe that the basic concept of the federal pay system, comparability with the private sector, is a sound one, but the concept has been destroyed by the discretion accorded to the President to cap pay. Pay has been capped in all but one of the adjustments provided workers.

The pay caps are chiefly responsible for the widespread use of the special rate in the VA. As this Committee is well aware the purpose of the special rate system was to complement the pay adjustment system in those areas where the local market conditions skewed the general rates. As the director for nursing services so succinctly stated "any time you have the exception to the rule becoming the rule ... it tells you the system isn't responding to reality" and with RN's in 172 installations receiving special rates and similarly high numbers for other health care groups, it is clear that the pay caps have destroyed the concept of comparability. If the pay caps were removed and comparability were allowed to govern then clearly, we wouldn't be experiencing these recruitment and retention problems. We believe the solution to the pay problems government wide and in the VA is to restrict the ability of Congress and the Administration to cap pay, and to establish a schedule for closing the pay comparability gap.

We also note that the bill allows for certain demonstration projects in the pay area, including a China Lake pay for performance project, and a cafeteria plan project. We have reservations about both of these concepts, but in general are supportive of demonstration projects so long as they are representative of the full range of accepted methods for setting pay including collective bargaining. It is our view that collective bargaining is the most equitable way to set pay and is a method commonly used in private hospitals. We urge the Committee to include collective bargaining in any demonstration project.

Our Union applauds S-13 and your leadership in addressing two personnel areas where VA professionals are unnecessarily accorded fewer rights than title 5 government workers; collective bargaining and grievance/disciplinary review.

Mr. Chairman, our Union supports provisions of S-13 which restores the collective bargaining rights of Title 38 employees stripped by the U.S. Court of Appeals for the D.C. Circuit last July in the case of Colorado Nurses Association and VA Medical Center, Ft. Lyon, Colorado v. FLRA 851 F2d 1986.

This decision creates additional impediments to recruitment and retention of VA personnel and unjustly denies rights to VA personnel which are accorded to federal employees. The VA department of medicare and surgery was created in 1946 and granted a separate personnel system to provide greater flexibility for hiring health care professionals. In 1973 Congress passed the Civil Service Reform Act which provided federal employees with basic collective bargaining rights. It was and is our interpretation that CSRA intended to cover Title 28 employees. However as discussed earlier the Appeals Court decided differently and has stripped away the previously enjoyed bargaining rights of these employees.

Our Union strongly supports provisions of S-13 which would restore the status quo in collective bargaining. Currently, VA professionals are at the mercy of management with respect to collective bargaining. Management has full discretion to participate or not in collective bargaining, and once agreement is reached management has the option of repudiating the contract at any time. Needless to say effective bargaining cannot take place under circumstances where the parties have such unequal rights.

In addition to being unfair to the effected workers the absence of meaningful collective baraining rights is an impediment to recruitment and retention. Collective bargainng is perhaps the most commonly used and effective means to provide workers with input into workplace decisions. Nurses are particularly concerned with having input into work place decisions. The absence of this right in the VA while similiar groups of workers in the private sector and in state and local governments provides an additional recruitment and retention problem.

S-13 would maintain the pre Colorado Nurses status quo with respect to collective bargaining. As such this is a reasonable and fair proposition and we strongly support passage of this provision.

Finally, Section 224 of S-13 provides needed changes to Title 28 Section 4110 discplinary/grievance review. Under current law Title 38 employees are limited to an in house review. This process has been cumbersome, time consuming and of questionable competence. Our attorneys practicing before the Section 4110 Board have commented that members are knowledgeable on medical matters, but frequently ingnorant with respect to conducting a fair hearing.

A good example of some of these major flaws is demonstrated by the experiences of a nurse at the Grand Junction, Colorado VA. This nurse, was investigated by the board in June of 1985 for alleged negligence occurring in 1984. While the investigation was pending she was removed from her position and placed in a non nursing slot. In July of 1986 the investigation was completed and she was charged with negligence, and the board proposed that she be fired. She was advised of her rights to a hearing and she elected to accept those rights. At this time she was transferred out of her position and out of nursing services until the matter could be resolved. The Board held a hearing in November of 1987 where she was represented by NAGE Counsel. The Board didn't make a decision until May of 1988 at which time she was completely exonerated of all charges.

During the three years she was waiting for the verdict, she suffered immeasurable damage to her professional standing and reputation. Since she was forced out of nursing for this time period, her knowledge and skills deteriorated and she had to attend refresher courses before resuming her work. She also suffered financial losses since she was denied within grade increases and promotion opportunities for these three years. Finally her professional reputation was damaged by the charges, and exacerbated by the three year delay in exoneration. A process this cumbersome is a disservice to both the employer and the employee.

A grievance/disciplinary procedure to be effective must be simple, fair, and expeditious. Employees facing discipline want the matter disposed of quickly so that they can escape from under the shadow these matters cast on their lives and careers. Employers want a quick decision because they realize the tutorial value of discipline can be lost on the individual if it is delayed too long after the alleged offense. Employers also realize that productivity is lost while the employee is awaiting the decision. The current appeal process thus serves neither labor nor management.

S-13 makes needed changes to improve the due process protections accorded to employees facing disciplinary review, and expands the role of the negotiated grievance process in addressing workplace complaints. The legislation improves employee protection against arbitrary management action while protecting traditional management rights with respect to professional employees. We regard this provision as a much needed reform which will provide fundamental rights long with held from Title 38 employees which will also improve recruitment and retention. We pledge our cooperation to enacting S-13.

The NAGE appreciates the opportunity to appear and testify on these important matters. We look forward to working with the Committee to address the problems of recruitment and retention, and due process throughout this Congress.

NATIONAL
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STATEMENT BY

THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES

BEFORE

THE SENATE COMMITTEE ON VETERANS' AFFAIRS

ON HEALTH CARE LEGISLATION

MAY 18, 1989

Mr. Chairman and Committee Members:

On behalf of the National Federation of Federal Employees, which represents a significant number of health care employees at the Veterans Administration, I appreciate the opportunity to appear before you today to offer NFFE's views on S. 947 and S. 13, bills introduced by **Chairman Alan Cranston**.

NFFE commends the Committee for its efforts to solve the growing recruitment and retention problem among health care workers in the VA. We agree with Chairman Cranston that "we must do all that we can to enable the VA to attract the best and brightest health care personnel into the system ... and to ensure that they receive respect and support both because it is right and because it will lead to better health care for veterans who need their attention."

We also agree with the Committee that the current compensation program for health care personnel is inadequate. Attempts to address nationwide nursing shortages and poor working conditions in VA hospitals have resulted in 127 of 172 VA Medical Centers requesting special pay rates in order to recruit and retain qualified personnel. That the entire special pay rate system was designed to function only in reaction to recruitment and retention problems, rather than preventing such situations, is another fatal hardship for the VA.

S. 947 addresses the question of how to attract and retain qualified health care personnel for VA hospitals by establishing competitive pay rates which would be based on surveys with competing employers, generally in the same geographic area.

The employees covered by this program would include registered nurses, registered nurse anesthetists, certified registered nurse anesthetists, physicians, dentists, podiatrists, optometrists, physician's assistants, expanded-function dental auxiliaries, clinical or counseling psychologists, certified or registered respiratory therapists, licensed physical therapists, licensed practical nurses and licensed vocational nurses.

NFFE has experience with a similar geographic compensation program, the Federal Wage System, which sets blue collar pay for Federal employees. Among the problems we have encountered with the FWS are the cumbersome processes of conducting the wage surveys; the unwillingness of some private employers whose workers match well with Federal employees to participate in the surveys; the lower morale in those areas where jobs are paid less, especially when productivity rates are high; and resentment in the instances where no pay raise is granted, despite the fact that nationally-set costs, such as health insurance rates, are skyrocketing. The potential exists for all of these problems to manifest themselves in the proposed health care pay program as well.

As an overall policy position, NFFE would prefer that any geographic pay system establish a nationwide pay floor for positions, then permit unions to negotiate increases for some or all positions and locations as needed. At a minimum, employees should receive an annual pay raise equivalent to the Employment Cost Index or the Consumer Price Index for purposes of keeping up with inflation.

Although S. 947 does provide for saved pay in instances where surveys indicate no pay raise is warranted or even that a pay decrease is called for, the absence of any annual cost-of-living increase could doom employees to a steadily decreasing standard of living. Such a prospect would hardly entice employees to the rural or economically hard-pressed portions of the country which experience shortages in health care personnel as well. It is important to remember that a large percentage of the health care workers belong to families that need two incomes to survive. Saved pay without the promise of cost-of-living increases may not be sufficient to lure personnel to a part of the country where their spouses may have difficulty finding work.

In terms of the survey proposal and other aspects of S. 947 there is one key element missing: the opportunity for employee participation through union representation at all levels of the process. NFFE firmly believes that the only way that the proposed competitive pay process will be equitably conducted is through the inclusion of union representatives. We urge that any legislation permit unions to bargain over all aspects of the program, ranging from advising the Secretary of the VA on the promulgation of survey regulations, down to the gathering of data for individual hospital centers. If the competitive pay rates are neither created equally, nor maintained equally, the system will fail in its stated goal of improving recruitment and retention of health care personnel.

I'd now like to discuss the methods for conducting pay surveys. NFFE understands from discussions with Committee staff members that there was a reluctance to include a great deal of precision on how the surveys should be run. Underlying this decision, there appears to be a strong belief by the members of the Committee that the VA Medical Directors are sincerely concerned about recruitment and retention problems, that the Directors have the expertise to conduct such a complicated procedure, that they would have adequate funds to do so, in short that there would be no motivation for anyone involved in the process to make any decision that would not help recruitment and retention in the VA.

NFFE's experience with the 143 wage surveys conducted every other year for wage grade employees indicates that this procedure is complicated and filled with the potential for error. Members of the lead union in the wage area participate in the survey process and are able to validate job matches, but even so, problems arise every time any survey is conducted. S. 947 calls for almost 200 surveys to be conducted every year. NFFE contends that despite existent mini surveys conducted for special pay purposes, most VA Medical Directors lack the expertise to conduct accurate surveys for all their health care personnel.

In addition, in the Federal Wage System, employee representatives play a role at the national level through their participation in the Federal Prevailing Rate Advisory Committee. No such role has been crafted for employee groups in S. 947. NFFE does not expect that it or any other union would ever have the majority position in such a body, but a minority role at least, as is held in FPRAC by union representatives, is essential.

If we are to be realistic about the prospects for a successful competitive pay rate procedure, we must recognize two facts: first, that VA Medical Directors constantly face funding shortages which seriously impede their ability to keep their facilities functioning, and secondly, that recruitment and retention are far from the only major hurdles to effective patient care. A Medical Director who faced a severe financial crisis for his or her facility, while at the same time needing to acquire expensive equipment or to provide a specialized new service, would have a motivation to influence any competitive pay rate survey. It would hardly be the first time that recruitment and retention was sacrificed at a VA facility in favor of other requirements. Nothing in S. 947 would prevent this from happening on a larger scale across the country.

S. 947 leaves much of the decision-making up to the individual Directors. Directors would decide which comparable hospitals they considered to be their competition for health care personnel. In some areas, such as New York City and Long Island, the selection of which hospitals to survey could have a significant impact on the final pay rates. How would the Directors know which hospitals they were in competition with?

Directors would decide how to weight the data in order to derive the final pay figures. Would large and small hospitals be weighted in the same fashion? Would geographic location be a factor? These are distinctions which could again make a major difference in final pay rates.

In the absence of comparable hospitals to survey, Directors would choose which non-comparable hospitals to include. This may be acceptable for some positions but not for others. How would the inclusion of non-comparable hospitals affect pay rates for positions not represented?

In the case of facilities located in rural areas, Directors would recommend which rural areas in the country most closely approximate their own. What basis would the Medical Directors be using to make this determination? Would professional labor economists be involved?

In the absence of interim final regulations from the Secretary of the VA, in fact, the Directors would be required to conduct pay surveys on their own. NFFE is quite concerned that without such regulations, the individual design of nearly 200 pay surveys will be chaotic.

Union participation at all these levels would improve the potential for success, as would union participation in the proposed pilot programs. NFFE endorses the concept of a collaborative practice committee, as this attempt to involve many levels of health care personnel in the agency's mission could generate improved morale as well as more effective care. In addition, NFFE endorses the pilot program to increase the pay differential for evening and night service; and the program to implement new alternatives for utilizing the skills and knowledge of registered nurses in furnishing direct patient care.

NFFE's support for a flexible benefits program would depend entirely on what benefits were included. The union is opposed to allowing individuals to trade away basic employment benefits such as health care and retirement coverage, but would be interested in working with the Committee to explore the possibility of including new benefits such as child care or transportation, to name only two examples.

The pilot program to establish alternative systems for grade, classification, pay, performance, qualifications, and other aspects of personnel management appears to NFFE to be an attempt to introduce the so-called "pay-for-performance" concept tested at China Lake, which has been widely discredited. In any new system of this sort, NFFE would insist on union participation in the design and implementation.

NFFE believes that a far better pilot program would test collective bargaining as a means to establish pay rates and performance requirements. Currently, 39 states and the District of Columbia permit bargaining over wages for at least some of the employees falling under their jurisdiction. In addition, the U.S. Postal Service has bargained over wages with unions representing postal employees since 1971. NFFE believes the time is ripe for pay negotiations in the Federal sector, and that a pilot program in the VA could be an excellent means to test this possibility for other Federal employees.

Finally, NFFE endorses the portions of S. 947 that lift the cap on overtime pay for nurses, and the 1% lump-sum payment for nurses who are recertified for a specialty.

I would now like to discuss S.13, which would restore collective bargaining rights of the Title 38 employees in the Department of Medicine and Surgery.

The right of Title 38 employees and their representatives to bargain over working conditions with management was eliminated in July 1988 when the U.S. Court of Appeals for the District of Columbia Circuit ruled that the VA is not required to bargain with employee representatives over working conditions of the DM & S employees. In the Colorado Nurses Association v. Federal Labor Relations Authority decision, the Court said that Congress intended to give the Administrator "unfettered discretion to issue regulations concerning working conditions of the Department of Medicine and Surgery employees."

This decision was a departure from the precedent of the last twenty years where bargaining between labor organizations representing Title 38 employees and the VA over proposals ranging from safety and health issues to training and career development of employees was routine.

While NFFE recognizes the justification for a distinct personnel system utilized by DM & S for its employees, it is clear that Congress intended to include Title 38 employees in the collective bargaining procedures contained in the Civil Service Reform Act and thus ensure that Title 38 employees are afforded the same fundamental rights as other federal employees in terms of labor relations.

We know of no situation in which the VA's mission of providing medical services was hampered in any way because employee representatives were bargaining with management over conditions of employment. In fact, the types of personnel procedures set forth in Title 5 have become the norm in federal labor-management relations since the current system was developed.

NFFE members feel that the provisions of S.13, which would provide Title 38 employees with collective bargaining rights, should be a cornerstone of any legislation to improve programs of health care for our nation's veterans. NFFE earlier supplied the Committee with documentation of the effects of management's refusal to bargain with employees represented by NFFE Local 387 in New York. Because of the Colorado Nurses decision, management has refused to bargain with employee representatives over working conditions.

What is occurring at Northport is instructive. Changes are made in working conditions, employees are notified and the union receives no notice or finds out after implementation. Either management refuses to negotiate or claims that the impact is *de minimus*, even when there is great adverse impact. The labor representative is not invited to discussions with management required by statute and management has refused to provide information because "the union doesn't need it to negotiate since management does not have to negotiate." While these disputes are ongoing, employees are being destroyed by unreasonable work demands and unfair treatment. The effects of management's refusal to bargain are lowered employee morale which compounds the problems of recruitment and retention of qualified staff.

I would like to briefly detail some of the examples we found at the Northport Hospital: For the sake of brevity today, I will outline only a few of the many examples of unreasonableness.

1. The laundry service was contracted out. Previously, laundry had been done by in-house laundry service at no cost to the patients. Suddenly patient laundry will no longer be done and staff also has been unable to obtain towels, sheets and pajamas. Nursing service was told that nursing would have to do patient laundry. This is not a nursing function,

but what is more unreasonable is the fact that staff is expected to do laundry without washers, dryers, soap and money. We are certain that the VA is saving money, but at whose expense?

2. When a crisis occurs on a psychiatric unit, nurses were at one time able to call a crisis team. The Mental Health Committee, however, decided to disband the crisis team without input by nursing management or the Union. The basis for disbanding the team was that the team was called on infrequently. However, without the crisis team, nursing is left with no one to respond or help. Often there is only one RN and two others working on the 4 p.m. to 8 a.m. shift. How are three individuals supposed to restrain and medicate an agitated patient while also caring for and protecting 30-45 other patients? Additionally, if nursing must send employees for laundry or supplies, it is readily apparent that nursing staff is required to do an impossible task with no support.

3. Management decided that nursing will be required to receive training in OREM's (deficit care therapy). Each unit will be stripped of staff in order to receive day tour training. A floating team will then cover the unit where they are unfamiliar with patients, routine, or location of equipment or supplies. As a result, support services are lacking and nursing must then do other functions' tasks. Staff has been forced to accept transfer assignments regardless of resulting hardships. Management can refuse to negotiate and under the Colorado Nurses decision, there is no recourse.

We do have one serious concern about S.13, however, relating to Section 224 of the bill, Disciplinary Actions and Grievances. We have no problem with Section 4110, since it would cover only non-bargaining unit employees, and therefore, exclude NFFE members. We do note, however, that the trigger for any appeals process would cease to be specific actions on the part of the employee, and instead become the type of punishment the employee receives. We are not aware why this change has been made, except, possibly to bring the Title 38 appeals process for non-bargaining unit employees in line with the Merit Systems Protection Board process. The protections for employees contained in this section appear to be inclusive, but again, it appears that they would not affect our members.

In contrast, the newly proposed Section 4120, which would affect only bargaining unit employees, causes many questions for us. The legislation requires that "[i]n the case of review of a disciplinary action involving any question of clinical competente, as determined by either party, any person selected to serve as an arbitrator in such case under procedures established as provided in paragraph (1) of this subsection must be qualified as an arbitrator and must also be (A) qualified as a physician, dentist, or nurse, or (B) otherwise qualified, by specialized experience or training or both, in examining and adjudicating health-care issues."

This seems a noble goal, but we are unsure that a sufficient quantity of such qualified individuals can be located. The Federal Mediation and Conciliation Service does not have any method of identifying arbitrators who possess specialized medical expertise. How and where would these individuals be located? If sufficient numbers are not readily available, we would counsel that this portion of the legislation be altered so as not to cause unconscionable delays in the grievance process while waiting for a new cottage industry to spring up.

That concludes my statement. I will be happy to answer any questions.

STATEMENT OF RICHARD S. CHRISTIAN, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
MAY 18, 1989

Mr. Chairman and Members of the Committee:

We appreciate the opportunity to offer The American Legion's views on the several proposals relating to veterans health care services scheduled for consideration at today's hearing.

With respect to S. 13, section 211 of title 38, United States Code, this measure would amend 601(6)(A) to expand the definition of "medical services" to include "(A)(i) surgical services, (ii) services to achieve pregnancy in a veteran or a veteran's spouse when such services are necessary to overcome a service-connected disability impairing the veteran's procreative ability."

The vast majority of those individuals who would receive this assistance are Vietnam veterans who, without the application of special procedures to overcome the service-connected impairment of their procreative ability, would not be able to parent natural children.

We believe there are a relatively limited number of veterans who would be eligible for these services and an even smaller number who would avail themselves of them.

In consideration of these circumstances, we would not oppose the intent of this section.

Section 213 would amend section 5033(A) of title 38, United States Code, to extend authorization for the State Home Construction Grant program from September 30, 1989 through September 30, 1992.

The American Legion strongly supports the proposed extension of the State Home program as it is an important link in Federal/State efforts to meet the needs of our aging veteran population. Currently, a total of 36 States operate 57 State homes with a total of 18,981 beds. The facilities provide acute hospital care - 689 beds, nursing home care - 11,580 beds, and domiciliary care - 6,712 beds.

Sections 214 and 215 would require the Secretary of Veterans Affairs to conduct, during fiscal years 1990 thru 1993, pilot programs to furnish assistive animals to certain quadriplegic veterans and to provide signal dogs to certain hearing impaired veterans, who are in need of such assistance.

Additionally, these provisions require the Secretary of Veterans Affairs to evaluate the pilot programs and submit to the Congressional Committees on Veterans Affairs by February 1, 1993 a report on the experience under the program. The report shall include the selection criteria for placing these assistive animals, the extent to which severely disabled veterans have benefited from the assistance of these animals, and the costs involved in conducting the pilot programs. The report shall also include the Secretary's views on the relationship between furnishing an assistive monkey or dog to a veteran in receipt of additional disability compensation or nonservice-connected pension benefits based on need of regular aid and attendance, and any recommendations of the Secretary as to whether the pilot program should be continued or whether the authority to furnish such assistive animals should be made permanent.

Mr. Chairman, we believe the pilot programs as proposed by sections 214 and 215 of this measure will afford the Department of Veterans Affairs the opportunity to conduct a broad evaluation of the costs and benefits of providing assistive animals to certain eligible disabled veterans. We are, therefore, supportive of the intent of these initiatives.

Section 222 would expand the Secretary's authority to enter into sharing agreements with medical schools, medical facilities and research centers throughout the country for the purpose of receiving and sharing the newest, advanced medical information, techniques and specialized medical resources not otherwise available. Medical facilities would be broadly defined to encompass various types of hospital facilities, organ banks, blood banks, or similar institutions. It also provides that the reimbursement rate under such sharing agreements shall be based upon a methodology which provides appropriate flexibility for the heads of the facilities concerned. Proceeds received under these agreements shall be credited to the facility furnishing the resource involved.

Many medical procedures which have been previously only performed in hospitals are now being performed in ambulatory care facilities. Health care providers in the private and public sectors are becoming more competitive, and if VA is to benefit from this competition, it must develop greater flexibility in the utilization of sharing agreements to obtain certain specialized medical resources from other medical care facilities. However, it must proceed cautiously in doing so.

We view this proposal as a cost-effective means for the VA to improve the quality of hospital care and other medical services provided veterans through the use of sharing agreements to secure or effectively utilize specialized treatment, care, or research resources which might not be otherwise available to the VA. Our concern would be that sharing agreements be interpreted within the strict meaning of the term, so that VA does not lose any of the control over its responsibility for providing medical care to veterans. Likewise, we would not condone the treatment of non-veterans in facilities where veterans are being turned away.

Section 225 of this measure proposes the Secretary of Veterans Affairs establish a task force to identify inconsistencies among provisions of title 38, United States Code (601(6), 612, 614, 617 and 619) relating to veterans' eligibility for certain health care benefits, and develop policy recommendations and legislative proposals to eliminate any such inconsistencies. The Secretary shall be required to submit to the Congressional Committees on Veterans Affairs the report of the task force and a report by the Secretary concerning the task force's recommendations and proposals.

Mr. Chairman, The American Legion believes the intent of sections 601(6), 612, 614, 617 and 619 of title 38, United States Code, as cited in this measure, is to provide VA with broad authority to make available a wide variety of medical care and rehabilitative services as well as prosthetic and assistive devices to certain eligible disabled veterans. The issues raised by this proposal are the VA's interpretation and implementation of these several sections, as to the nature and extent such services and equipment shall be furnished, discussed on the introductory statement of January 25, 1989.

The proposed task force, in the course of its review of the cited provisions of the title, is to address any inconsistencies identified in the statutes as well as problems in properly implementing both the intent and provisions of the law.

While generally supportive of the establishment of a task force for this stated purpose, The American Legion's overriding concern is that although there may be a perceived need to further clarify the nature and scope of the VA's authority in providing specialized care, services and equipment to disabled veterans, there is also a need to ensure the continued viability and availability of such programs as intended by Congress.

S. 165 proposes the Department of Veterans Affairs construct a medical research center at the Medical University of South Carolina at Charleston. The construction and equipping of this facility would be under a cost sharing agreement with the State of South Carolina and the Medical University of South Carolina would pay one half of such cost. The Secretary may enter into an agreement with the Medical University for joint ownership, management and use of the research center. The purpose of this research center shall be for medical research activities, including such areas as geriatrics, diabetes, heart disease, arthritis, and connective tissue disorders. This measure would appropriate $12 million, as the VA's share of the construction cost of this facility.

Mr. Chairman, the Veterans Health Service and Research Administration has had sharing agreements with hundreds of medical schools and universities for the sharing of resources and facilities. None, to our knowledge, has involved the joint construction and ownership of a facility. This proposal presents an innovative concept. However, there are many VA renovation and replacement projects which have gone unapproved or been delayed because of limited budget resources.

In our view, there are a large number of planned construction projects throughout the VA medical care system which are needed to provide additional direct care and services to veterans. We are wholly supportive of research being carried out within VA. However, we are concerned about the state of the VA medical care system currently, and feel that scarce resources could be better used.

S. 573 would amend section 629(A)(2)(D) of title 38, United States Code, to provide for third party reimbursement for the cost of health care and services furnished a service-connected veteran for a nonservice-connected disability.

Mr. Chairman, The American Legion is mandated by Resolution No. 278, adopted during its 1988 National Convention, to support amendatory legislation to Public Law 99-272 and Title XIX of the Act that shall retain the entitlement provisions of the Act while eliminating the requirements for the means test and third party reimbursement. We have consistently opposed these programs over the past several years through resolutions adopted by our National Conventions. We believe the means test and third party reimbursement programs have changed the nature of the VA health care program by making it a cost-sharing program rather than a benefit program as intended by Congress.

Since Public Law 99-272 was enacted we have witnessed one move after another which has further restricted veterans' eligibility for VA care. However, aside from that, to The American Legion it is not in the best interest of our nation's veterans to think of applying the third party reimbursement to a service-connected veteran. We are totally opposed to this provision.

S. 574, titled the "Veterans Health-Care Program Improvements Amendments of 1989", section 4 would authorize VA, under section 614 of title 38, United States Code, to provide assistive simians and dogs to veterans suffering from service-connected quadriplegia. It would further require the Secretary of Veterans Affairs to report to the Congressional Committees on Veterans Affairs by October 1, 1992 on the conduct of this program, including the Secretary's evaluation, findings and conclusions concerning the provision of such assistive animals to severely disabled service-connected veterans.

Mr. Chairman, we note a similar proposal to provide assistive monkeys and dogs to certain quadriplegic veterans was included in section 214 of S. 13. As previously stated with respect to that proposal, The American Legion is supportive of this initiative which seeks to improve the quality of life for such severely disabled veterans.

Section 5 of this measure would repeal section 615 of title 38, United States Code, which provides authority for the VA to furnish tobacco products to veterans receiving care in VA hospitals or domiciliaries.

Mr. Chairman, The American Legion opposes the repeal of section 615. In addition, we are opposed to totally smoke-free medical centers. We feel that each facility should have designated smoking areas. Likewise, it is the Legion's position to oppose removal of tobacco products from the canteens.

Section 6 would amend section 620(B)(c) to extend the VA's authority to provide respite care to September 30, 1991. It would also extend the deadline for the submission to Congress of the report on the respite care program as directed by Public Law 99-576.

The American Legion fully supports these provisions. As the veteran population grows increasingly older, their medical care needs also increase. Respite care, as provided by the VA, has proven itself to be a cost-effective alternative to hospital and/or nursing home care. Furthermore, it has already benefited many veterans and their families by allowing the veteran to remain in his or her home environment, rather than being institutionalized. These benefits could be afforded to many more veterans under the proposed 2 year extension of the program.

Section 7 of this bill would add a new section 620C to title 38, which would authorize VA, in the case of certain service-connected veterans in need of or receipt of VA nursing home care or contract nursing home care, due to a service-connected disability, to provide on a contract basis health and health-related services in a noninstitutional setting.

In addition, the Secretary of Veterans Affairs would submit a report to the Congressional Committees on Veterans Affairs by December 31, 1992 setting forth the Secretary's evaluation, findings and conclusions regarding the conduct of the new program established under section 620C.

Mr. Chairman, The American Legion strongly supports the establishment of new noninstitutional alternatives to nursing home care. New and innovative approaches to providing appropriate care and services for eligible geriatric veterans within the VA medical care program are urgently needed. This proposal represents a positive step in that direction.

Section 8 would amend section 4107(f) of title 38, United States Code, to authorize premium pay for certain nursing assistants.

In certain geographical areas, it has been difficult for the VA to recruit and retain well qualified nursing assistants under current salary criteria. This proposal will allow the VA greater flexibility in obtaining and maintaining badly needed nursing personnel through the use of special pay incentives. At the meeting of The American Legion National Executive Committee on May 11, 1989, Resolution No. 7 was adopted to support legislation to improve compensation and special pay to certain health-care professionals. The American Legion urges favorable consideration of this measure.

This section would also amend section 4107(i) of title 38, United States Code, to authorize retired military nurses to be employed by the VA without loss or reduction of their military retirement pay.

Currently, under section 4107(i), the VA may exempt retired military physicians from the pay offset provisions of section 5532 of title 5, United States Code. The proposed extension of a similar exemption to retired military nurses would, in our judgment, overcome the deterrent to recruitment and retention posed by the current restriction and help improve the severe shortage in nursing personnel in the VA.

S. 748, the "Department of Veterans Affairs Health Care Programs Extension Act of 1989" would amend section 612 of title 38, United States Code to authorize the provision of outpatient dental services and treatment where medically necessary in preparation for hospital admission.

This proposal would permit VA to provide limited outpatient care to veterans scheduled to have certain types of hospital care where a dental condition might pose a threat of infection or adversely affect the veteran's treatment. Currently veterans who require such dental treatment prior to procedures such as cardiac valve replacement, coronary bypass surgery, hip and knee prostheses, radio-therapy and others must enter the hospital and remain until the condition has resolved. Treatment of a dental condition on an outpatient basis is a far more cost-effective means of preparing a veteran for hospitalization than utilizing an acute care bed for this purpose, as it lessens the overall length of hospital stay. The VA estimates a cost savings of $520,000 a year if such veterans could be treated on an outpatient basis in preparation for hospitalization rather than having to hospitalize them in order to provide such necessary dental treatment.

The American Legion supports this additional authority for VA as it will enable the medical centers to more effectively utilize their resources for those veterans in need of inpatient care.

This measure would also increase the limit on the yearly amount for authorized non-VA dental treatment from $500 to $1000. Currently, the Secretary of Veterans Affairs may authorize treatment or services in excess of $500 based upon an examination by a VA dentist or VA fee-basis dentist. Public Law 96-151 established the present $500 limit on non-VA outpatient dental treatment. Ten years ago, this amount may have been a reasonable limit in determining whether or not VA would require a second opinion as to the necessity of such treatment. In many areas now, the cost of non-VA dental treatment has become very expensive and as a result VA has incurred additional expenses associated with having the veteran examined by a VA dentist. Likewise the veterans have been burdened with delays in being scheduled for an appointment and the necessity of travel to the VA dental clinic. It is estimated that approximately 11,000 veterans annually are required to receive a second opinion for dental treatment exceeding $500, and that the number of such veterans would be reduced to approximately 2,000 annually if the limit were raised to $1,000. This would produce a cost savings of $594,000 for FY 1990 alone. Another tangible benefit of increasing the limit before a second opinion was required would be to allow critically short dental resources to be utilized on direct dental care for eligible veterans.

The American Legion supports the proposed increase under section 612(b)(3).

S. 748 also proposes the extension of support to the State Home Grant program through Fiscal Year 1994 and would authorize the appropriation of $42 million for Fiscal Year 1990.

The State Home Grant program is an important and effective means of meeting the increasing demands for all types of health-care by our aging veteran population. It has also served to substantially lessen the burden of caring for many thousands of veterans that would have otherwise been borne by VA.

Under the proposed funding for Fiscal Year 1990, the six approved projects will make available 760 nursing home care beds and 326 domiciliary beds. This is in addition to the 11,580 nursing home care, and 6,712 domiciliary beds in the state veterans' home program nationwide.

Mr. Chairman, The American Legion National Executive Committee at its meeting on May 11, 1989, adopted Resolution No. 6 to support legislation to provide for a more equal partnership between State and Federal Governments in State Veterans Homes. This program is considered to be a wise investment and we offer our strong endorsement to the continuation of Federal support of the State's efforts to care for their veterans.

This measure would also extend VA's authority to provide respite care through Fiscal Year 1991. The American Legion was most supportive of the establishment of the respite care program, under Public Law 96-576, as was previously stated in addressing section 6 of S. 574. Respite care offers the spouse or other loved ones a much needed period of rest and an opportunity to take care of necessary business.

The American Legion is strongly supportive of the continuation of this program.

S. 900 - This bill would amend section 620B(c) of title 38, by extending for one year, through September 30, 1990, the authorization for VA to furnish respite care to certain chronically ill veterans. It would also amend section 201(b)(2) of the "Veterans' Benefits Improvement and Health-Care Authorization Act of 1986" by extending for one year the due date required of the Secretary for providing the final report to evaluate the potential benefits and cost-effectiveness of respite care, to the Congressional Committees on Veterans Affairs.

As previously stated, we support the two year extension.

The last bill under consideration today is S. 947, "Veterans Health Care Personnel Act of 1989." This bill consists of four legislative proposals addressing pay matters, personnel benefits, health care education, and personnel management matters, respectively.

Section 101 would amend Chapter 73 of title 38, United States Code, by inserting a new section 4107A which will provide for competitive pay rates for certain nurse and other health care professional positions. The major thrust of this provision is to allow the VA to become more competitive with non-Department health care facilities in the recruitment and retention of qualified health care personnel, on the basis of pay and other employee benefits.

Section 101 would also require the Director of each Department health care facility to conduct initial and annual market surveys to establish the rates of basic pay in each pay grade provided for such positions.

Section 102 would amend section 4107(e)(5) by establishing specific rates of pay for nurses who perform officially ordered or approved hours of service in excess of forty hours in an administrative workweek, or in excess of eight hours in a day.

Section 103 would amend section 4107(e) by providing head nurses with additional pay for each hour of service performed as a head nurse, when service as a head nurse exceeds a period of no less than 30 consecutive days.

Section 104 would provide for a waiver of reduction in military retired pay for health care professionals and other personnel, involved in providing services incident to direct patient care.

Section 105 would provide special rates of pay for certain employees in the Veterans Health Service and Research Administration.

Section 106 would amend section 4107 to provide for consideration of professional specialty certification pursuant to providing additional nurse pay in certain specialties.

Mr. Chairman, we appreciate your concern and efforts toward improving the competitive standing of VA health care personnel. Recruitment and retention of health care personnel by the Department of Veterans Affairs is a problem which begs for a permanent solution if the Department is to continue its mission of providing quality health care and medical services for the nation's eligible veterans. Numerous hearings over the past decade or more have led to stopgap measures which have offered only temporary solutions to chronic recruitment and retention problems. Some of the problems relate to nationwide shortages of certainhealth care personnel and others to geographic inadequacies of VA pay scales as compared to identical positions in the private sector. In some areas the existing problems relate to a combination of the two.

The provisions of S. 947 appear to improve substantially the medical center directors' capability to establish competitive wages and benefits for health care personnel.

These amendments demonstrate a need for improvement in the ability of VA to recruit and retain nurses and other health care professionals. The American Legion views this proposal favorably, as it would undoubtedly be an improvement over the current pay structure.

Section 201 would add new section 4120A which will provide the Secretary of Veterans Affairs authority to pay a cash award to Department supervisors and managers. It would also require the development of a dependent care assistance program for the care of dependents of employees in the Veterans Health Service and Research Administration.

There is a need for further clarification of the intent of this provision. Therefore, The American Legion recommends, in view of the resources necessary to implement such a program, that a study be conducted by the Secretary of Veterans Affairs to determine the feasibility of such a program.

Section 301 would amend section 4312(B)(5) of title 38, United States Code, to ensure an equitable allocation of scholarships to persons enrolled in the second year of a program leading to an associate degree in nursing.

Section 302 would amend section 5091 of the title by clarifying the process in which the development of new health care careers is accomplished. It would also amend Subchapter III of Chapter 82 by authorizing the appropriation of $5 million annually for fiscal years 1990 and 1991, and $6 million annually for fiscal years 1992 and 1993 to support the continuation of the VA grant program to assist in the education and training of professional and other health care personnel.

The American Legion is supportive of these proposals.

Section 401 would amend section 4106 of title 38, United States Code, to authorize the Secretary, upon the recommendation of the Chief Medical Director, to appoint in the competitive service, any individual who meets certain clinical education criteria.

Section 402 proposes the Chief Medical Director to conduct a pilot program at not less than five Department medical centers during calendar years 1990, 1991, and 1992, designed to improve recruitment and retention of nurses and other health care personnel, as well as other employees in which the Department is experiencing recruitment and retention problems.

Section 402 also describes the conduct of the pilot program to be implemented by the Chief Medical Director and establishes the timeframes in which the Chief Medical Director and the Secretary of Veterans Affairs shall report on the experience of the pilot program.

Mr. Chairman, we believe these proposals are designed to aid recruitment and retention efforts within the Department. In our view, they will assist in developing long-range strategies to improve the overall direct care capabilities of the Department.

Mr. Chairman, this concludes our statement.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS
May 18, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.2 million members of the Disabled American Veterans and its Ladies' Auxiliary, I appreciate the opportunity to appear here today to present our views on various legislation relating to the Department of Veterans Affairs Health Care System.

Mr. Chairman, your letter of invitation to testify solicited our views relating to various pieces of legislation requiring this Committees attention and action.

Our testimony has been requested regarding the following: S. 13 (Sections 211, 213, 214, 215, 222, 223, 224, and 225) the "Veterans Benefits and Health Care Act of 1989"; S. 165; S. 573; S. 574; the "Veterans Health-Care Program Improvements Amendments of 1989"; S. 748, the "Department of Veterans' Affairs Health Care Programs Extension Act of 1989"; S. 899; S. 900; and S. 947, the "Veterans Health-Care Personnel Act of 1989".

S. 13

Section 211 of the bill proposes, through appropriate amendment to Clause (A), Section 601(6), Title 38, USC, to include in the definition of medical services "...services to achieve pregnancy in a veteran or a veteran's spouse where such services are necessary to overcome a service-connected disability impairing the veterans' procreative ability..."

While the DAV has no official position to the perceived intent of this measure, we feel explanatory report language is required to express the limitations of this bill.

Our interpretation is that services would be provided to "...achieve pregnancy..." (emphasis added). Therefore, we do not envision the VA to be required to provide obstetric services, prenatal or postnatal care in conjunction with any successfully achieved pregnancy. We would also raise the issue of the VA's potential liability relating to possible complications and/or permanent disability to the mother or possible birth defects affecting the child.

Section 213 proposes appropriate amendment to Section 5033(a), Title 38, USC, extending, for three years, until September 30, 1992, the VA's authority to provide grants for the construction, acquisition, expansion, remodeling and alteration of state veterans homes.

Mr. Chairman, Section 214 proposes the conduct of a four year pilot program to provide -- "(A) to not more than 20 quadriplegic veterans who have service-connected disabilities rated 50 percent or more, monkeys that are specially trained to assist in the performance of daily living tasks for quadriplegic individuals, and (B) to not more than 10 such veterans, dogs that are so trained; and (2) facilitate the furnishing of monkeys that are so trained to not more than 20 quadriplegic veterans".

Mr. Chairman, although the DAV has no official position regarding this issue we are in agreement with and applaud the perceived intent of this measure -- to permit the greatest possible degree of independence to quadriplegic veterans and to substantially improve their quality of life, as well as that of their families.

As proposed by Section 215, the VA would be directed to conduct a four year pilot program (Fiscal Years 1990-1993) to furnish signal dogs to not more than 20 veterans with service-connected hearing impairments.

Although we have no official position on this measure we are supportive of its favorable consideration by the Committee. Also, we would suggest language attaching a priority to the furnishing of such dogs, when appropriate, to the profoundly hearing impaired veteran.

Section 222 proposes amendment to Sections 5051 and 5053, Title 38 USC, regarding the sharing of specialized medical resources by expanding the types of medical facilities which the Administrator is authorized to enter into agreements with in order to share the most advanced medical techniques, information and certain specialized medical resources.

The DAV has no official position regarding this provision, however, if veteran patients will potentially benefit from such an expansion of authority, we could be supportive of its favorable consideration.

Section 223 proposes, via appropriate amendment to Section 4108, Title 38, USC, to cover personnel employed in the health care system under the federal employees collective bargaining procedures. The DAV is supportive of this measure.

The DAV has no official position relative to Section 224 regarding disciplinary actions or grievances, however, we have no objection to its favorable consideration.

Section 225 proposes the creation of a Task Force to be established by the Secretary to, ..."recommend policies and legislation for the elimination of inconsistences among provisions of law relating to veterans eligibility to certain health care benefits".

Mr. Chairman, we do not necessarily disagree with your assessment that the various sections of Title 38, USC, pertaining to veterans eligibility for medical and assistive devices lacks consistency and clear meaning.

We are not convinced, however, that the creation of a Task Force, as envisioned in this provision, is the preferable way to proceed to eliminate any inconsistences in the application of law.

Specifically, we wish to relate our concern regarding the composition of the Task Force and the absence of any non-DVA representation. If, in the wisdom of the Committee, it is felt that a Task Force is indeed warranted, then we urge amending language be inserted directing that at least two representatives from Veterans Service Organizations (VSOs) be appointed to such a Task Force.

We believe it is imperative that VSOs be involved in the front end and be active participants in any dialogue that occurs relating to this issue which is of utmost concern and importance to the most severely disabled service-connected veteran.

S.165

Introduced by a distinguished member of this Committee, Senator Thurmond, this measure proposes to require the VA to construct a medical research center at the VA medical center and the Medical University of South Carolina in Charleston, South Carolina.

The cost of constructing this facility would be borne equally by the VA and the University, with subsequent joint ownership, management and use of the facility.

Mr. Chairman, the DAV applauds Senator Thurmond for his introduction of this measure laying further witness to his interest and commitment to the VA research program and welfare of our nation's disabled veterans.

However, in an era of severe budgetary constraints on the health care system, including very scarce medical construction funds sorely needed for renovation, modernization, and nursing home construction we find it difficult to endorse a project of this nature.

S. 573

Introduced by Senator Murkowski, Ranking Minority Member of the Committee, S. 573 proposes to amend Section 629(a)(2), Title 38, USC extending the VA's authority to recover -- third party reimbursement -- the cost of care provided to a service-connected veteran treated for a nonservice-connected disability.

Mr. Chairman, the DAV is adamantly opposed to this measure.

In our view, S. 573 contains the obvious theme of radically restructuring the veterans health care system in an overly restrictive manner and sends a clear signal to service-connected disabled veterans that yet another earned benefit and entitlement is being stripped from them.

A secondary theme exists: to simply discourage and force a large number of veterans away from the VA thus diminishing the base and patient mix of veterans accessing and utilizing the system. The end result is simply a foothold at dismantling the system to a point of ineffectiveness.

In this regard, we view this proposal as an attempt to require veterans to pay for the privilege -- extended by Congress and a grateful nation -- of utilizing earned VA benefits and, in fact, entitlements under current law.

Additional concerns become readily apparent which deserve some discussion and further buttresses our view that this measure is not in the best interest of disabled veterans, nor for that matter the VA.

We believe the adjudicative/administrative nightmare that would be opposed on the VA would be exceedingly burdensome and create havoc in a system already taxed to the breaking point.

As an illustration, consider the case of a World War II veteran service-connected for an amputation of the lower extremity, upper third, resulting from combat incurred gunshot wounds who is admitted to a VA medical center and treated for chronic lumbosacral strain with degenerative disc disease.

At the time of admittance and, in likelihood at the time of discharge, from the hospital and for some time thereafter the veteran's chronic back condition may not be an adjudicated service-connected disability.

Under the provisions of S. 573 the VA would, presuming the veteran had health care insurance, initiate action to collect the reasonable cost of care and services provided from the insurance carrier and, in fact, receive reimbursement.

However, at some point in the process a claim will have been filed and adjudicative action taken by the Veterans Benefits Administration to grant service-connection for the chronic back condition as a logical consequence and proximate result of the service-connected amputation.

It is not unreasonable to consider a claim of this nature would require, under the most favorable scenario, a minimum of three months to a maximum of 413 days to adjudicate under normal conditions utilizing the appellate process.

How then, Mr. Chairman, is the entire process rectified concerning the responsible third party payer?

Let's examine the ramifications of S. 573 under the budget process regarding VA health care.

Under current law whatever monies VA is successful in collecting ($105 million of the $275 million billed in FY 88) is deposited in the United States Treasury.

It is currently estimated -- by OMB -- that in Fiscal Year 1990 some $304 million will be collected from the VA from third party reimbursements. If, in the formulation of future VA budgets the amount collected and retained by VA are calculated and considered in the overall health care account then the current budgetary shortfall would be greatly exacerbated as the collectable estimates are grossly overstated and the actual amount collected considerably less than estimated.

This would, therefore, result in a further depression ($136 million in Fiscal Year 1990) of total VA funds available for health care services in Fiscal Year 1990.

Mr. Chairman, the provisions of S. 573, if enacted into law, would be bad for veterans and bad for the VA. We reiterate our adamant opposition to this measure and urge the Committee to reject this proposal.

S. 574

Introduced by Senator Murkowski, Ranking Minority Member of the Committee, Section 3 of S. 574 purposes technical amendments to be made to Section 101, Title 38, USC. The DAV has no objection.

Section 4 proposes to grant the Secretary permanent authority to provide assistive animals (simians and dogs) specially trained as assistive animals to any veteran who, by reason of quadriplegia, is entitled to disability compensation.

As previously indicated, we have no official position regarding this issue. However, due to the somewhat unique nature of the concept of utilizing assistive animals to aid disabled veterans, as well as to ensure the continued availability of a sufficient number of trained animals, we support the provisions of S. 13 requiring a pilot program in this regard.

Section 5 proposes to repeal Section 615, Title 38, USC, granting the Secretary authority to furnish tobacco to veterans receiving hospital or domiciliary care.

Mr. Chairman, the DAV has endorsed the initiative to make VA hospitals "smoke free". We support reasonable efforts and actions causing cessation of smoking by employees, patients, and visitors in the acute hospital care setting. Therefore, we support this provision.

The DAV supports extending the VA's authority to furnish respite care as contemplated by Section 6.

Mr. Chairman, Section 7 purposes to add a new section -- 620 C, "Non-institutional alternatives to nursing home care" -- to Title 38, USC.

This section would require the VA to establish a program for the furnishing of medical, rehabilitative, and health related services in non-institutional settings for veterans who;

* are eligible for nursing home care; and

* are in receipt of or in need of nursing home care primarily for the treatment of a service-connected disability.

Initially, Mr. Chairman, I want to state that the DAV supports this concept. We have long advocated that providing necessary medical and certain non-medical services to veterans to avoid institutionalization is a desirable approach, both from a cost effectiveness standpoint and, more importantly, for the overall well-being of the veteran.

Mr. Chairman, to enable these provisions to succeed in their intent, we feel it desirable to define, in part, what is envisioned by the term "health related services." This term should, in our view, include, but not be limited to:

Domestic	Custodial
Bathing	Assistance with daily needs
Feeding	Turning patients
Grooming	Catheter irrigation
Changing patient's clothes	Massage
Oral hygiene	Ambulation
Dressing	Sitter services
Diet Management	Changing colostomy bags
	Changing simple dressings
	Changing external catheters

Medicine Administration
Assistance with prosthetic devices
Position adjustment/transfers

Homemaker
Housecleaning
Food Preparation
Marketing
Washing clothes

Because we believe that flexibility in providing these types of non-medical support services is essential to obviate the need for institutionalization, we suggest, if this measure is favorably reported, that such services be defined as cited above.

Additionally, Mr. Chairman, we are pleased to note that this measure envisions that the Secretary shall give priority for participation in the program to veterans with service-connected disabilities, as well as other veterans (Category A) who, by virtue of their disabilities, would be most in need of such services.

Section 8 proposes amendment to Section 4107, Title 38, USC, extending certain pay enhancements to VA nursing assistants (premium pay) and registered nurses (waiver of reduction in military retired pay). We are supportive of these provisions.

S. 748

This measure, introduced by yourself, Mr. Chairman, at the request of the Department purposes in Section 2, to amend Section 612(b)(1), Title 38, USC, to permit outpatient dental treatment to be performed on a outpatient basis when medically necessary in preparation for a veterans' admission to the hospital.

Our initial reaction to this proposal is favorable in that veterans will receive the treatment they require without the more costly requirement that they first be admitted as an inpatient. However, we are withholding support until clarifying information is forthcoming satisfying our concern that veterans requiring dental treatment will actually receive it on a outpatient basis.

Section 3 would, via appropriate amendment to Section 620B(c), extend authority to provide respite care for two years until September 30, 1991. We support extension of this authority.

Section 4 would amend Section 5033(a) to authorize to be appropriated $42 million for Fiscal Year 1990 and such sums which may be necessary for each of the four succeeding fiscal years for the State Home Grant Program.

Mr. Chairman, the DAV is extremely supportive of this program. We are of the opinion that it provides a cost effective, viable alternative to providing needed medical and long-term care services to this nation's entitled veterans. As such we support this measure.

S. 899

This measure, introduced by yourself, Mr. Chairman, by request, would amend Section 4108, Title 38, USC, granting the Secretary authority to establish and conduct for five years, a leave sharing program for employees of the Veterans Health Services and Research Administration.

Although the DAV has no official position regarding this measure we would not object to its enactment.

S. 900

Introduced by a distinguished member of this Committee, Senator Rockefeller, S. 900 proposes to extend, for one year until September 30, 1990 the VA's authority to provide respite care to certain chronically ill veterans.

As we have previously indicated, the DAV is extremely supportive of the continuation of this very worthwhile and effective program. Therefore, we are supportive of its favorable consideration by the Committee.

S. 947

Introduced by yourself, Mr. Chairman, S. 947, the, "Veterans Health-Care Personnel Act of 1989", represents an extremely comprehensive and far reaching measure designed to provide the VA the necessary authority and flexibility to recruit and retain qualified health care personnel.

The major provisions of this measure include:

*requiring the Secretary to take appropriate steps to establish and maintain levels of pay competitive with the private health care sector for certain health care professionals;

*requiring VA to pay overtime to registered nurses, nurse anesthetists and certified nurse anaesthetists at the rate of one and one-half times the hourly rate of basic pay;

*requiring the Secretary to provide pay differentials to nurses appointed to head nurse positions;

*authorizing the Secretary to make cash awards to managers and supervisors of certain defined professional groups;

*authorizing the Secretary to establish and operate a dependent care assistance program for health care employees;

*authorizing the VA to hire, without regard to the normal Civil Service process, VA trained health care professionals as specifically defined;

*reducing, from 90 to 45 days, the period in which a request for special pay may be disapproved;

*enhancement of the VA Health Professional Scholarship Program;

*authorizing appropriations for Fiscal Years 1990-1993 to reinstitute health care professional education programs;

*requiring VA to conduct a pilot program regarding management practices at VA medical facilities;

*increasing the cap on special salary rates;

*expanding the Secretary's authority regarding waiver of reduction of military retirement or retainer pay;

*requiring the Secretary to conduct a leave transfer program; and

*requiring bonus pay to be paid to each nurse upon recertification in a clinical speciality.

The DAV is supportive of any and all action that would achieve the goal of assisting the VA in their efforts to recruit and retain competent qualified health care professionals. In our view, the provisions outlined in S. 947 can only serve to assist the Department toward that end.

Mr. Chairman, you are to be commended for your continued recognition and commitment to ensure that an adequate cadre of qualified health care professionals are employed within the VA health care system in order to provide quality medical services to this nation's disabled veterans. As we look back over the years it becomes readily apparent that many of the enhancements in the area of employment of health care professionals have enjoyed both your advocacy and your untiring support. For that, you have the sincere gratitude of the DAV.

It is a pleasure, therefore, to extend the full support of the DAV to the general provisions of S. 947.

This concludes our testimony, Mr. Chairman, and I would be pleased to address any questions you may have. Thank you again for allowing the DAV to present our views on these important issues.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR

FOR GOVERNMENT RELATIONS

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITEE ON VETERANS' AFFAIRS

MAY 18, 1989

CONCERNING

S. 13 - THE "VETERANS BENEFITS AND HEALTH CARE ACT OF 1989"

SECTIONS: 211, 213 - 215, 222 - 225

ADDITIONAL VA HEALTH CARE PROGRAM IMPROVEMENTS CONTAINED IN

S. 165, S. 573, S. 574, S. 748, S. 899, S.900

AND,

S. 947 - THE "VETERANS HEALTH CARE PERSONNEL ACT OF 1989"

Mr. Chairman and Members of the Committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our views on a series of newly introduced legislative initiatives designed to expand, extend and improve veterans' health care programs and services.

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Before I begin, however, on behalf of the membership of PVA, I would like to express our appreciation to you, Mr. Chairman, and the Members of this Committee for your help and advocacy in seeing that funding totals for veterans' health care programs were raised significantly during deliberations over the fiscal year 1990 budget resolution. Your efforts to investigate the actual impact of the current funding crisis facing the Department of Veterans Affairs (DVA) dramatically portrayed to the Congress the human cost of the present serious situation. Your budget views and estimates set a realistic mark for what the actual needs of the system will be next year and in years to come. The amendment to the budget resolution introduced by Senator Rockefeller which you cosponsored, Mr. Chairman, along with Senators DeConcini, Harkin and Riegle, was a major first step in helping to make up part of the projected shortfall for next year.

We still have a long way to go before the total needs of the health care system can be addressed adequately through the appropriations process. We look to your continuing help, advice and influence as that next funding hurdle approaches. But it is still appropriate at this point to stop and express our thanks to you for your continuing support and understanding. It is reassuring, indeed, to know that the veterans' voice is still heard through such good friends in the United States Senate.

S. 13, Section 211 "Services To Overcome Service-Connected Disabilities Affecting Procreation"

Mr. Chairman, again on behalf of the membership of Paralyzed Veterans of America, I want to thank you for your leadership on this important issue. For the third year in a row you have introduced legislation which would authorize the DVA to provide available medical assistance to veterans who are unable to have children due to a service related disability to help them overcome that disability.

As we have stated in the past, it seems most unreasonable, if not unconscionable, that the Department will compensate a veteran for loss or loss of use of one or more creative organs (Section 314 (K) of title 38 U.S. code), but will not afford the same veteran access to medical care to mitigate or overcome the resultant condition. Up until a few years ago, most spinal cord injured males were told two things: first, you will never walk again; and, second, you will never have children. Today, thanks to advanced and accepted medical technology, for many spinal cord injured veterans, the latter just does not have to be true any more.

Many of these procedures are relatively new, that is true. Because of this fact, there has been some controversy or hesitancy on the part of the Department and others to endorse this legislation. However, if this test were applied to any new medical procedure or technique, the overall health care and medical assistance provided to veterans would be extremely limited. New medical procedures and benefits would never be acceptable or applied. At the same time, the vast majority of the techniques which would be endorsed by this legislation, some as simple as fertility counseling, have been accepted as being commonplace by the medical community for decades and would greatly serve the vast majority of veterans seeking assistance to have children.

As you know, Mr. Chairman, PVA, too, has struggled with this problem. For the past three years we have watched with frustration as veterans have had to go without fertility treatment because authorizing legislation has stalled due to the debate over whether or not in vitro fertilization techniques would be provided for in the final bill. We do not assess blame on any side of this issue. We fully understand and appreciate the deep feelings held by both the House and Senate Veterans Affairs Committees in this matter. We are also completely stymied by the overriding ethical and political considerations espoused by both sides which take this debate far beyond our control and influence and far beyond the venue of veterans' affairs.

For these reasons, after consulting both sides, it is clearly apparent that neither side is willing to bend or offer any compromise acceptable to both. If it were a perfect world, and, if veterans were not waiting to have babies based on the outcome of this debate, Mr. Chairman, we would, as we have in the past, support your bill which grants the authorization but leaves the itemization of what services to provide, including in vitro fertilization, up to the DVA. But, as you know, the stalemate will only continue. There will be no authorization. The DVA, once more will be let off the hook for another year. And, service-connected spinal cord injured veterans will once more have to go without one of the most precious gifts: the gift of life and the gift to bear and raise children.

Certainly we may be guilty of equivocation in this matter. But any equivocation comes from our frustration that, first veterans eligible for these services, particularly those PVA members who would avail themselves of treatment, are not getting any younger. And, quite frankly, the medical efficacy of many of these procedures, most of them very routine in nature, wanes with age and the longer the period of time following injury.

We fully support the concept of in vitro fertilization techniques and the rights of those women veterans who would be acceptable candidates for this procedure and all fertility procedures. We pledge our full support to defend and protect those rights whenever they are abridged. However, while in vitro is excluded in the House bill, H.R. 1931, and your bill would leave its provision up to the DVA, it is the last and wholly specialized final step in a long process of fertility treatment which would be available and authorized for any female veteran by both bills. For this reason, in vitro becomes a clear exception in the fertility treatment process and not generally the rule for treatment that the vast majority of women would seek or for which they would be acceptable candidates.

Quite clearly, in vitro is also the stumbling block that has, and apparently will continue to block passage of any authorizing legislation. As such, it will continue to prohibit any fertility treatment to be given to any eligible veteran, both male and female. We believe the issue of in vitro should be set aside from this debate. PVA is willing to continue the battle for authorization for in vitro fertilization either in the Congress or the courts; but not in the context of this legislation and not at the expense of damaging what we believe are the clear rights of any other eligible male or female veteran seeking fertility assistance from the DVA.

Mr. Chairman, this has been a difficult decision to reach, particularly because of our deep appreciation and strong support for your leadership on this issue. But we have waited in frustration for three years for the Congress to resolve this debate over a matter, in our opinion, which the Department has always had the clear ability to authorize on its own. In the interest of the vast majority of veterans seeking procreative services, we believe it is essential to move forward with authorizing legislation, which, even without in vitro at this point, will still provide a comprehensive array of services for the vast majority of veterans seeking to have children.

S. 13, Section 213 Extension And Funding of State Home S. 748, Section 4 Grants

Section 213 of S. 13 would extend from September 30, 1989, to September 30 1992, the grant program for the construction or renovation of state veterans homes. Section 4 of S. 748 would authorize $42 million to be appropriated for fiscal year 1990 and such sums as may be necessary for each of the four succeeding fiscal years. The State Veteran Home program has been recognized as one of the most cost effective means of increasing the availability of long term care services for veterans by having the DVA and the states share in the cost of construction, renovation and operation of these facilities. PVA strongly endorses these provisions.

S. 13, Section 214 Pilot Program for Furnishing Assistive Animals To Certain Veterans

S. 574, Section 4 Assistive Animals for Certain Disabled Veterans

Section 214 of S. 13 introduced by you, Mr. Chairman, and Section 4 of S. 574, introduced by Senator Murkowski would authorize the DVA to provide assistive animals, simians and canines, for eligible service-connected quadriplegic veterans.

Senator Murkowski's bill would provide general authorization followed by an evaluation and report. We greatly appreciate his leadership on this issue. The Chairman's bill would require the VA to establish a pilot program to provide simians to not more than 20 veterans service-connected for quadriplegia rated 50 percent or more, and similarly trained dogs to not more than 10 such veterans. S. 13 would also require an evaluation and report.

As you know, Mr. Chairman, PVA has reviewed both these programs and has found that, under the proper circumstances, assistive monkeys and dogs can be of great benefit in improving the quality of life for catastrophically disabled individuals. Monkeys, and the simple tasks they perform, are not a replacement for attendant care provided by family members or paid professionals. However, they can provide a respite from the continuous care and supervision required by many high level quadriplegics in performing many routine assistive functions.

With regard to S. 574, PVA cannot determine any compelling reason not to support permanent authorization of this important service. However, understanding that the supply of properly trained monkeys, in itself, over the next few years will limit the number of veterans who could utilize this service, we believe that a pilot program as described in S. 13 to be the best approach at this time.

PVA has serious concerns regarding Section (d)(2)(B) of the provisions which requires the Secretary's views on the relationship between the the provisions of a monkey or dog and ~~the payment~~ of aid and attendance or pension allowance to the veteran. Assistive animals are a proven and effective supplement to, not substitute for, aid and attendance to quadriplegic veterans. The provision of this service has never been intended to replace or compete with the absolute necessity of human intervention. The presence of a specially trained monkey in the veteran's household can, however, have a very positive effect on the ability of the veteran to recruit and retain attendant caregivers, by helping to increase the functional independence of the quadriplegic individual.

PVA has been concerned about the inadequacies of the VA's aid and attendance provisions for quite some time. We do not believe however, that analysis of the DVA's provision of aid and attendance is appropriate as part of this legislation. PVA would be happy to work with the Committee in another context with the purpose of conducting a review of the overall adequacy of the aid and attendance program.

S. 13, Section 215 Pilot Program for Providing Signal Dogs To Certain Veterans

PVA fully support this provision which would require the DVA to establish a pilot program providing signal dogs to not more than 20 veterans who have service-connected hearing impairments. The provision of these assistive animals as well has proven to be an effective and worthwhile supplement to increasing the functional independence of disabled veterans.

S. 13, Section 222 Sharing of Specialized Medical Resources

PVA supports the intent of the provision which seeks to expand the authorization for the DVA to broaden its ability to share a wider variety of medical resources and services in the national medical community. Sharing of resources and services has proven to be a cost-effective and rational means to enlarge the DVA's capacity to provide quality comprehensive health care.

S. 13, Section 223 Coverage of Veterans Health Services and Research Administration Personnel By Federal Employees' Collective Bargaining Procedures

PVA supports this provision which would provide certain DVA health care personnel the same protections regarding collective bargaining as are currently provided other civil service employees by Chapter 71 of title 5 U.S.C.

S. 13, Section 224 Disciplinary Actions and Grievances

PVA supports this provision which would mandate specific procedures for action and reaction to disciplinary actions and grievances for DVA health care personnel. Adequate and consistent standards of procedure and due process are a fundamental component of employee stability and satisfaction. Both the employee and the employer must be assured that definitive procedures and recourse are available to protect both whenever a disciplinary action is rendered or a grievance petitioned.

S.13, Section 225 Development Of Recommended Legislation For The Elimination Of Inconsistencies In Certain Veterans Benefits Laws

PVA supports the need for a generalized review of provisions of law relating to veterans' eligibility for certain health-care benefits to isolate and correct any existing inconsistencies. It is very clear to us, particularly in the case of procreative services for example, that there is a sharp disagreement on the intent of the existing statute and the interpretation of that statute by the DVA. Such inconsistences perennially create conflict between the DVA and the Congress, forcing the legislative branch to redirect the Department's reluctance to properly implement existing statutes by the passage of additional correcting legislation piecemeal. This is a time consuming and frustrating process.

While the need is clear to correct this problem, PVA is not convinced that the task force as called for in this provision will be adequate to properly and objectively address this problem. The provision calls on the Secretary of Veterans Affairs to appoint members of his own staff to the task force in order to, in effect, police themselves. The legislation also is not clear as to the areas of benefits, services or entitlements the task force would study and then recommend be changed or amended.

PVA believes that if such a task force is created, and if legislation is actually needed to create such a task forced, the members of the task force should be compiled from a broader spectrum of individuals, including veterans services organizations.

S. 165 Medical Research Center for the DVA Medical Center
And University of South Carolina

The legislation, introduced by Senator Strom Thurmond, would authorize $12 million for the DVA portion of a new medical research center to be built in conjunction with the University of South Carolina in Charleston, South Carolina. PVA applauds the long history of support of our nation's veterans exhibited by the Senior Senator from South Carolina. We have also testified in the past on the need to expand and improve the DVA's award winning research programs. However, judging the fiscal shortfalls currently facing the entire DVA health care system, including its construction programs, we cannot support this legislation at this time. PVA, because of the composition of its membership has an expressed interest in the construction of spinal cord injury centers. We note with concern that just last year, undoubtedly because of budget shortfalls, the VA was forced to delay one SCI center project in Dallas, Texas, and eliminate another SCI project which had been planned for Gainesville, Florida altogether. The timely reinstatement or realignment of both those projects must be our major concern at this time.

S. 573 To Provide For Third-Party Reimbursement For The Cost Of Health Care And Services Provided To Service-Connected Disabled Veterans

This legislation, introduced by Senator Murkowski, would provide for third-party reimbursement for the cost of health care are and services furnished all service-connected disabled veterans for the cost of all services provided to treat non service-connected disabilities. PVA opposes enactment of this legislation.

The service-connected disabled veterans has always received the highest priority of care and consideration within the Department of Veterans Affairs. Current law provides that service-connected disabled veterans with disabilities rated in the highest categories, above 50 percent, can receive care for all conditions, whether they are directly related to their service-connected disability or not. Those service-connected disabled veterans rated below 50 percent currently can only receive priority care for that disability. PVA is concerned that this legislation represents a serious encroachment on the integrity of the priority assigned to service-connected disabled veterans, particularly those veterans with the most severe disabilities. We also question whether their would be any true savings as a result of the provision.

Naturally, if the DVA were able to recoup payment from private health care insurers for the cost of this care, undoubtedly the federal treasury, not the DVA, would receive additional dollars. But at the same time, by passing on the cost of this care to the private sector, the DVA would be contributing to the already soaring inflation rates in national health care. A service-connected disabled veteran who is fortunate enough to have private health insurance for himself and his family will soon enough see the cost of these health care services passed back to him in the form of increased monthly premiums. It was never the intention of past policies or current law to force these service-connected disabled veterans to pay for their own health care when the DVA is required to provide those services free of charge. This proposal, through an "indirect billing process" would ultimately pass the cost of care right back to the veteran.

S.574, Section 5 Repeal Of Authority to Furnish Tobacco To Veterans Receiving Hospital or Domiciliary Care

PVA has no official position on this provision. However, we would like to caution that we would not like to see a situation whereby hospitalized veterans, particularly veterans hospitalized for long-term disabilities, such as domiciliary residents, lose ready access to the acquisition of tobacco products. The nature of smoking as a habit realistically includes the fact that habitual smokers denied access to tobacco will eventually find some way of acquiring tobacco products. If they are not readily available for sale within the confines of DVA facilities, those veterans, particularly veterans with incapacitating disabilities, will have to resort to underground blackmarket activity to meet the needs of their habit. As we have testified on previous occasions, we believe that tobacco products should continue to be available for sale and purchase in VA facilities.

Extension Of Authority To Furnish Respite Care

S. 574, Section 6

Introduced by Senator Murkowski, this provision would extend for two years, until September 30, 1991 the authority of the DVA to provide respite care. It would require the submission of a report on respite programs in 1990.

S. 748, Section 3, introduced by Senator Cranston would also extend respite programs for two years, (1991), and would require the report to be submitted in 1991 as well.

S. 900, introduced by Senators Rockefeller and Cranston would extend respite programs for one year (September 30, 1990), and require the report to be submitted by February 1, 1990.

PVA believes that respite care is one of the most innovative alternatives to institutional long term care services. Providing intermittent hospitalization or home care services not only helps the veteran with long term chronic disability, but, most importantly, also provides a needed break for the caregiver from the routine day-to-day tasks of caring for the veteran. Undoubtedly, in our opinion, if more respite care were available to provide relief for family members caring for veterans in their own homes, the DVA and the veterans themselves in many situations could avoid or postpone entirely the expense and discomfort of institutionalization.

PVA supports a two-year extension of this program.

S.574 Section 7 Noninstitutional Alternatives To Nursing Home Care

This important provision introduced by Senator Murkowski requires that the DVA establish a program for the furnishing of medical, rehabilitative, and health-related services in noninstitutional settings for veterans eligible for nursing home care, or veterans in receipt or in need of nursing home care. The legislation gives priority to service-connected veterans.

The aging of the veteran population clearly indicates that the DVA must find innovative means of avoiding the staggering cost of institutional long term care services. Not only can the DVA save dollars constructing new nursing home beds and hiring support staff, but clearly, for most veterans with chronic disabilities, the home setting can be the best location for care and rehabilitation. Quite often, at the present time, institutionalization becomes the only alternative for care when the veteran does not have the resources, or the DVA does not have the means to provide home care assistance.

For many PVA members, catastrophically disabled spinal cord injured veterans, attendant care and home care services are an obvious necessity. However, it does not take very much, just the inability to perform one or two routine tasks of daily living at the most, to force an individual into a nursing home situation when adequate care, maintenance and monitoring are not available in the home.

PVA wholeheartedly supports Senator Murkowski's legislation which would furnish appropriate health related services through contracts with appropriate public and private home health care agencies. The legislation would also establish case management services which we feel are an integral part of analyzing each individual veteran's needs and the mix of services required to meet those needs. We note with concern at the present time that many DVA medical centers are having to curtail and ration their hospital based home care programs, providing only those services which can be construed solely as medical clinical necessities. We would encourage with enactment of this legislation that the DVA be able to expand their home care programs to include not just direct medical support in the home, but the provision of maintenance and home support services as well.

S. 748, Section 2 Dental Services

This provision would clarify the authorization for the provision of dental services on an outpatient basis and raise the current $500 limit on contract dental services to $1,000. PVA is concerned about the rising cost of health care services which certainly must be shared by the dental profession. The current $500 cap set for services without a second opinion and approval from a VA dentist, undoubtedly is met and exceeded more often than not. At the same time, the cap does place cost controls on the program, ensuring that the DVA can monitor the provision of needed care and dental services. PVA believes the Committee should look carefully at this proposal, but also look cautiously. The cost of care for the entire DVA medical system has risen and continues to rise. Unfortunately, the dollars to pay for that care have not. In the light of the fiscal restraint currently surrounding the Department, any increase in the cost of care for one service undoubtedly will have to be taken from dollars to provide care for another.

S. 899 DVA Employee Leave Sharing Program

This legislation introduced by Senator Cranston at the request of the Administration would authorize a leave sharing program for DVA employees. The provision would allow employees to donate or share leave to co-workers

who are faced with medical emergencies. Leave sharing is a straightforward and compassionate means of encouraging one employee to help another who, faced with an incapacitating long term illness would have no other alternative but to lose his or her job and benefits. The bill would provide a five-year pilot program. We believe this important program deserves permanent authorization.

S. 947. THE "VETERANS HEALTH CARE PERSONNEL ACT OF 1989"

Mr. Chairman, PVA is aware of your long history of addressing the problems plaguing the nursing service of the Veterans Health Services and Research Administration (VHSRA). We wish to thank you for your efforts to improve recruitment and retention of nurses which directly affect the quality of health care provided to our nation's veterans. You have made the statement in the past--with which PVA is in full agreement--"We must do all that we can to enable VA to attract the best and brightest health care personnel into the system," therefore, PVA is supporting S.947. PVA views this legislation as having a positive effect in solving the recruitment and retention difficulties facing VA nursing staff today.

PVA is deeply concerned about the shortage of nurses in the VA today, which in many aspects reflects the national nursing shortage and the declining pool of available nurse professionals. However, VA's problems are unique and as such, must be addressed with equally unique solutions.

The present professional nursing shortage is a phenomenon which has affected many aspects of health care since the early 1970's. In recent years the shortage of registered nurses (RN) reached such a critical level that the Secretary of Health and Human Services formed the Secretary's Commission on Nursing to study the issue. In the findings released in December 1988, this commission reinforced to the public, as well as health-care providers, that the nursing shortage was a real problem which required attention.

This commission reviewed testimony from groups such as the American Nurses Association (ANA) which reported that as of 1987, there were an estimated 2 million nurses nationwide, and 78% of this number were employed in the profession. However, this large number of nurses has not been sufficient to fill the estimated 11.3% vacancy rate nationwide. Factors which have influenced the supply of nurses, as reported by the commission, include: 1) expanded career opportunities for women, 2) declining student population, 3) decreasing subsidies for education, 4) wage rates, 5) problems with retention, 6) the effect of Aids, and 7) the image of nurses.

Although the total number of nurses has grown each year since the 1970's, the demand for nurses has exceeded the supply--thereby creating the shortage we are now experiencing. This need for nurses has been influenced by several issues; consumer requirements for health services, and economic and institutional considerations that affect the employers preferred mix of personnel.

A nursing shortage of such severe proportions as the one we face today has multiple effects on the delivery and quality of health care. As the availability of nurses decrease, the work load of the remaining nurses increase, thus resulting in a diminished level of care being provided to the patient. The Commission heard testimony which indicated that the increased work load of the nursing staff led to increased medication errors and "patient falls from bed." Studies reinforced this testimony by documenting a direct relationship between low nurse staffing levels and a higher incidence of medical complications among patients. PVA considers this level of care to be unacceptable. As the Commission stated in their report, " Nursing is the only profession with 24 hour responsibility for patient care in the majority of heath-care settings, therefore, the availability and utilization of nurses obviously has important indications for the quality of patient care."

The Department of Veterans Affairs, the nation's largest health-care provider, has not been exempt from experiencing the nursing shortage and its effects. In the 1980's the VA addressed the quality of care issue in their medical facilities by decreasing the number of patient beds available in relation to the number of nurses present to care for patients. In some cases, whole wards have been closed and the opening of new wards has been delayed due to the lack of nursing staff. To counter this problem, VA's goal is to recruit and retain an adequate number of nurses and other health-care professionals to ensure that our nation's veterans will not be denied necessary health care. However, an "adequate" staffing level will be difficult to determine since staffing requirements for DVA have not been developed.

Once an adequate nurse staffing level has been developed, which takes into account such things as nurse-patient ratios, staff mix and the level of care the patient requires, then the DVA will have a tool by which to guide

recruitment of nurses. Full time equivalents (FTE) (although they are not equal to a certain number of RNs but assist hospitals in judging adequate numbers of staff) are not appropriate measures of a nursing shortage, nor are they appropriate recruitment tools because the FTE level only takes into account "budgeted" nursing positions. And in the case of the VA, vacancies which have existed for an extended period of time have been eliminated thereby altering the number of FTE's required by each facility. Therefore, FTE's do not address the "silent" demand for nurses, the proportion of nurses engaged in bedside care, or the "appropriateness" of nurse utilization.

To recruit nurses, the Department must first define its target group. In order to determine the market it will address, DVA must review essential statistics. RNs form the largest group of health-care providers in the Department. Of the 34,867 RNs in 1988, 78.5% of them are employed full-time. The average age of the DVA nurse is 42-44 years. In nationwide studies, the ANA reports that of the 2 million nurses present today, 78.7 % are employed in nursing and of this group 36.9% are under the age of 35. Reviewing these figures one notes that 21% of the total number of nurses are not currently employed, and that a large percentage of nurses are at the age when family formation is a priority. Nationwide statistics from the commission indicate that 44% of nurses with children only work part-time. Therefore, it can be concluded that the target group of nurses for the VA to recruit are these three groups mentioned above; those who are not employed, the nurses under age 35, and those nurses who work only part-time.

Since the number of hours nurses work per week is associated with the nurses' marital status and number of dependents at home, these factors must be addressed in order to recruit them. It has been noted that the majority of VA nurses are employed full-time, and only a small percentage have young children.

Therefore, since the supply of nurses has increased over the years -- but has not kept pace with the demand -- the short term solution to DVA's nursing shortage can be found in three steps. First, encourage part-time nurses to turn to the VA for employment with increased hours of work per week. Second, encourage those nurses who are unemployed to return to both nursing and the DVA, and third, retain these nurses within DVA. The long term goal is, of course, to increase the total supply of nurses.

In order to recruit the nurse who has young children, the VA must provide an image which is both appealing and which addresses his/her personal and professional needs. Such concerns include:

1. Flexible scheduling which includes full or part-time work, 4,8,10,12 hour shifts, and use of the Baylor plan.

2. Affordable day care on campus with extended hours and allowances for children with mild illnesses.

3. Establishment of float pools of VA nurses who choose to float to various nursing areas instead of permanent

assignments. This would replace the need for agency nurses and decrease the pulling of permanent staff to other nursing units which are short-staffed.

4. Salary adjustments with increased shift differential.

By offering a system which offers professional autonomy, a national professional network, and geographic mobility without compromising retirement plans, DVA offers more security to the nurse than most employment opportunities. Studies indicate that 55% of the staff nurses in the Department have remained for 5 or more years, as compared with the low 1-2 year tenure of nurses in other systems. Yet the issue of retention must be addressed, especially since the cost of replacement of a single RN is approximately $20,000.

To retain nurses in the DVA the issues which must be addressed are:

1. Salary. The salary of nurses presently in the system must not be compressed but maintain competitiveness with similar markets. Sufficient raises must also be provided to give the nurse incentive to maintain his/her seniority with VA.

2. Professional growth. Encouragement to pursue professional and personal growth must be maintained by various educational opportunities such as scholarships, tuition reimbursement,

in-house continuing education, and recognition of certification. A clinical ladder must be developed to promote nurses who wish to remain at the bedside instead of progressing to positions in nursing administration. It is also essential to promote nursing leadership to provide an image of highly educated professionals for staff and students to emulate.

3. Working conditions. Greater involvement in policy formation and decision making can be achieved by placing a staff nurse or managerial nurse on hospital-wide committees and by promoting the "team" approach to health-care. The nurse should be recognized as a health-care professional with exceptional insight and expertise just as in the case of physicians, therapists, nutritionists, etc.

4. Flexible benefits. Benefits offered to the nurse must continue to be flexible in order to meet the nurse's needs. As the population grows older, retirement and educational benefits will become more important. It is interesting to note that some university based hospitals already offer free tuition to spouses and reduced tuition to children of employees. These are benefits packages which the DVA will be competing against to recruit and retain nurses with whom they will staff their medical centers and provide quality care for the veterans of the nation.

Legislation has been introduced in both houses of Congress to address the recruitment and retention difficulties which the VA medical system is experiencing. There is no "quick fix" for the nursing shortage and a bandaide will only mask the problem. However, if each of the needs of the nursing profession is addressed and nurses are respected as the patient-care coordinators that they are, the DVA will attract many educated and qualified health-care providers.

S. 947. TITLE I--PAY MATTERS

SEC. 101. PAY RATES FOR NURSES AND OTHER HEALTH-CARE PROFESSIONALS IN CERTAIN POSITIONS.

PVA fully supports the provisions contained in Section 101 of S. 947. Competitive pay rates for nurses as well as other health-care professionals must be addressed if VHSRA is to attract qualified personnel. The provision addresses the important issues of geography, wage compression, timeliness and their effect on competitive salaries. These are needed improvements designed to give The Department more flexibility in adjusting pay rates to meet fluctuations in market conditions and improve basic pay scales.

S. 574, SEC. 8 PAY ENHANCEMENT FOR DEPARTMENT OF VETERANS AFFAIRS NURSE AIDES AND NURSES.

Section 8 of S. 574, introduced by Senator Murkowski, addresses the pay of nurse aides (NA) and licensed practical nurses (LPN). PVA has long supported pay enhancement for these two categories of nurses since they provide most of the "hands on" care required by our membership. An appropriate mix of nurse aides, licensed practical nurses and registered nurses are needed to provide the high quality of care our veterans deserve.

SEC. 102. OVERTIME RATES OF PAY FOR CERTAIN NURSES.

PVA supports this provision which would adjust the overtime pay rate for nurses to allow for competitiveness with other health-care facilities vying for the same limited pool of nurses. Since requesting nurses to work over 40 hours per week (on a volunteer basis) is frequently the short term solution to staffing difficulties, appropriate incentive for this request must be provided. Therefore, the hours of family time which the nurse forfeits in order to work extra hours for the VA must be financially compensated at a rate of one and one half times the nurse's hourly wage.

The overtime pay rate described in this section is an appropriate and necessary recruitment and retention tool. For this reason, we also suggest that the Committee consider applying this amendment to all nurses. In order to maintain morale as well as appropriate staff mix, the licensed practical nurse (LPN) working overtime along side the registered nurse (RN) should receive the same overtime compensation of one and one half times his/her hourly wage.

SEC. 103. ADDITIONAL PAY FOR HEAD NURSES

The 6% pay differential for nurses appointed to the head nurse position is an important concept which we also support. Head nurses are first-line managers who provide an important link between the staff nurse and administration. Not only is the head nurse responsible for the quality of patient care provided to veterans on his/her unit, but also serves as a role model and resource to staff nurses and students. Without nursing leadership, and/or mentors, a positive image of nursing in the DVA will fail to be projected, thereby adversely affecting recruitment and retention of nurses.

A competent head nurse must possess excellent nursing, communication, and leadership skills. Therefore, to attract such individuals their skills must be recognized with financial compensation as they would be in any other profession. The growing vacancy rate for head nurses (22.4% in FY 88) is alarming and PVA agrees that legislation to address this problem is urgently needed.

SEC. 104. WAIVER OF REDUCTION IN RETIRED OR RETAINER PAY FOR REGISTERED NURSES.

PVA supports the provision to waive reduction of retirement pay for all occupations providing patient care services or services upon which patient-care is dependent. It is only reasonable that a retired health-care professional from the Armed Forces, who wishes to remain employed in their field of expertise, not be penalized for working with the veterans of our nation. This legislation would enhance the Department's ability to successfully recruit from a vast pool of untapped resources--the retired military sector.

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SEC. 105. SPECIAL RATES OF PAY FOR CERTAIN EMPLOYEES IN THE VETERAN HEALTH SERVICES AND RESEARCH ADMINISTRATION.

As you are aware, nurses are not the only health-care professionals who are in short supply and high demand in the VHSRA. Respiratory therapists, occupational therapist, pharmacists, and physical therapists are important components of the health-care team who also are in short supply. These professionals are needed to provide the high level of care required by increasing numbers of aging veterans entering the DVA system. Therefore, PVA supports the increased rate of special pay described in Section 105.

PVA also believes that the provision that requires that the Secretary be notified when 94% of this special pay rate has been reached is an important element in this legislation. This provision should allow for future timely adjustment of salaries thereby permitting the agency to remain competitive.

SEC. 106. CONSIDERATION OF PROFESSIONAL SPECIALTY CERTIFICATION.

Although certification is not required for nursing licensure, it is a credential of expertise in a specialized area of nursing. Certification is an expensive, time consuming process which demonstrates advanced knowledge and experience possessed by the nurse. It is a process that is recognized by both peers and colleagues and is pursued by the professional, career oriented nurse which the Department should recognize as a genuine asset. Therefore, PVA supports this provision authorizing financial recognition of certification.

However, it is suggested that the Committee clarify this section and include the same benefit upon certification as well as recertification, which PVA believes was the original intent of the proposed legislation.

TITLE II--OTHER PERSONNEL BENEFITS

SEC. 201. HEALTH-CARE PROFESSIONALS CASH AWARDS.

PVA supports this provision in which the Secretary may pay cash awards to supervisors or managers. Since head nurses are included in the definition of managers, this provision is seen as yet another tool to retain qualified, experienced leadership in the VHSRA.

SEC. 202. DEPENDENT CARE ASSISTANCE.

Mr. Chairman, PVA believes, after reviewing a variety of statistical data, that the short term solution to the Department's nursing shortage lies in the recruitment from a large pool of part-time nurses. Since 44% of registered nurses with children work part-time, PVA proposes that a large market of nurses has not been tapped as a resource by the Department. DVA should take steps to make its system more appealing to these nurses by addressing their needs. Once these nurses are recruited into the security of the DVA system, efforts must be made to retain them and encourage these part-time employees to increase their hours of work per week. The provision described in Section 202 addresses the need of many nurses presently working only part-time by authorizing the Secretary to establish dependent care assistance programs. PVA is in full support of this excellent recruitment tool.

We notice that many VA hospitals provide day care to their employees. However, for day care to be an effective recruitment and retention tool, it must be: 1) affordable, either through low rates or tax deductions, 2) located with in the geographical boundaries of the nurses' place of work, and 3) available 24 hours per day. Many hospitals competing with DVA provide day care as an employee benefit, however, only 20% provide day care around the clock.

Also if day care is to be provided as a recruitment tool, the issue of maternity leave (6-12 weeks of paid or unpaid leave separate from sick or annual leave) should also be considered. Another retention tool to be considered is assistance for the care of an elderly adult or handicapped child.

SEC. 203. LEAVE TRANSFERS AND LEAVE BANKS FOR CERTAIN HEALTH-CARE PROFESSIONALS.

PVA supports the establishing of leave banks for health-care professionals. It is an innovative benefit which assists not only the young mother, but parents of an ill child and employees with severe illnesses. Leave banks also provides a means by which employees can contribute direct aid to their colleagues.

The provision which allows the Secretary and the Director of the Office of Personnel Management (OPM) to enter into an agreement which would allow DVA employees to participate in the OPM leave transfer program is especially innovative and worthy of PVA's support.

TITLE III--HEALTH-CARE EDUCATION

SEC. 301. HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM AWARDS.

Although PVA does not wish to belittle the value of the baccalaureate prepared nurse, PVA does support equitable allocation of scholarships to nurses in associate degree programs. March 1988 statistics from the Department of Health and Human Services illustrate that a similar number of nurses (28%) hold associate degrees as compared to those holding baccalaureate degrees (30%). However, the associate nurse can earn her degree in only two years in contrast to the four years of education required for the baccalaureate prepared nurse. Therefore, since nurses are in short supply, and great demand, it is only reasonable that scholarships be awarded to persons enrolled in the second year of associate degree nursing programs.

SEC. 302. ASSISTANCE TO HEALTH-PERSONNEL EDUCATIONAL INSTITUTIONS.

PVA supports this provision which authorizes the DVA to carry out a program of grants designed to expand the training of health-care personnel. Since the DVA is the nation's largest health-care provider, every effort must be made to build a pool of qualified professionals committed to it's organization. This outcome can be accomplished by exposing health-care professionals and technical workers to the high quality of care furnished there.

SEC. 401. EMPLOYMENT OF PERSONNEL TRAINED BY THE DEPARTMENT OF VETERANS AFFAIRS.

PVA supports this provision which permits the Secretary to appoint qualified individuals in the competitive civil service without certain restrictions. Once again, this provision enhances the Department's ability to recruit certain highly qualified individuals. It broadens the pool of available talent and further enables the Secretary to provide highly qualified staff.

SEC. 402. PILOT PROGRAM OF PAY AND PERSONNEL MANAGEMENT PRACTICES.

A 1983 report by the Institute of Medicine (IOM), which studied efforts to encourage nurses to remain or re-enter the profession, identified several key areas to be addressed in order to increase job tenure. These areas were, 1) salary structures, 2) greater involvement in policy formation, and 3) improved working conditions. Although similar studies have been conducted since 1983, the same key factors have been listed as job dissatisfiers.

PVA agrees with the Chairman in that the issues listed in Section 402 should be evaluated in terms of their affect on recruitment and retention of health-care professionals within the VHSRA. It should be noted that the National Institutes of Health, Clinical Center initiated a recruitment program several years ago which included higher wages, differentials for undesirable shifts, improved working conditions and internal management, tuition support, performance recognition measures and a national marketing campaign. This program led to a decreased RN "turnover" rate from 22% in 1985 to 9% in 1988 and a reduced RN vacancy rate from 98 in 1987 to 7 in January 1988.

With such success possible, PVA supports the establishment of pilot programs to study pay and personnel management practices. However, it will be difficult to evaluate the implementation of recruitment and retention tools without formalized VA staffing guidelines. VA competitors,--in terms of nurses--have staffing instructions in place and even nursing homes will have federally mandated staffing requirements as of 1990. The resulting effect of these staffing guidelines will only increase the demand for nurses. Therefore, it is suggested that to anticipate future staffing difficulties, the issue of staffing requirements also must be addressed in the pilot programs for study contained in S. 947.

Mr. Chairman, S. 947 is a positive step in solving the health-care recruitment and retention difficulties of VHSRA. PVA strongly endorses this initiative and wishes to thank you for introducing this legislation which will improve health care for the veterans of our nation.

This concludes my formal statement. I will be happy to respond to any questions you may have.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

HEALTH CARE LEGISLATION

WASHINGTON, D. C. MAY 18, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 2.2 million members of the Veterans of Foreign Wars of the United States, I wish to thank you for the opportunity of appearing before this distinguished Committee to express our views on several pieces of legislation affecting the health care of our nation's veterans. By holding this hearing, you demonstrate your continuing concern that veterans receive the best care possible from a greatful nation.

Mr. Chairman, in your letter of invitation, we were asked to comment on Sections 211, 213-215, and 222-225 of S. 13. This bill, introduced by you and Senators Matsunaga, DeConcini and Rockefeller, is entitled the "Veterans Benefits and Health Care Act of 1989".

Section 211 of S. 13 would authorize the Department of Veterans Affairs (VA) to furnish services to help a female veteran or a male veteran's spouse to achieve pregnancy in cases in which the veteran's service-connected disability impairs the procreative ability. It is a matter of record that the VFW supported similar

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VFW MEMORIAL BUILDING • 200 MARYLAND AVENUE N.E. • WASHINGTON, D.C. 20002-5799 •AREA CODE 202-543-2239

legislation which was introduced in the last Congress. It is our strongly held conviction that service disabled veterans comprise a very special segment of the veteran population and that they are due very special treatment by the Federal Government in order to overcome and better live with their varying disabilities. Certainly, the inability to conceive a child is a source of great pain and distress to anyone so afflicted, and any individual who is so disabled through service in the Armed Forces should not be denied the joy of rearing his or her own child(ren) if it can be helped. Once again, the VFW strongly supports this legislative proposal. We would suggest to the Committee that consideration be given to expand the legislation to include assistance in the adoption of a child. This can only be viewed as a compassionate move both for the concerned veteran but also the adoptive child.

Section 213 would extend State Home Construction Grants until September 30, 1992. The VFW supports this program and encourages its continuation.

Section 214 provides for a pilot program to furnish assistive animals to certain veterans. The VFW commends the Chairman for recognizing the importance of this program and introducing legislation that would require the Secretary to implement such a program. This pilot program will improve the quality of life for those veterans suffering from quadriplegia and it enjoys the support of the VFW.

Section 215 of the bill calls for the establishment of a similar pilot program for providing certain veterans with signal dogs—dogs specially trained to help deaf individuals overcome their hearing impairment. The VFW supports this provision.

Section 222 would expand the VA's authority to enter into sharing agreements of specialized medical resources. This expansion would add to hospitals other facilities such as organ banks, blood banks, research centers, etc. The VFW supports the medical sharing program and has no objection to its being expanded under section 222 of S. 13.

Section 225 would provide for the development of recommended legislation for the elimination of inconsistencies in certain veterans benefits laws. The VFW recognizes that there are instances where inconsistencies do exist and does not oppose enactment of this section of S. 13. However, we strongly urge the Committee to amend the language so as to provide that the veterans service organizations be a part of the task force.

Sections 223 and 224 address the issue of collective bargaining and disciplinary actions and grievance procedures. The VFW has no resolutions addressing these issues and therefore has no official position.

Mr. Chairman, S. 165, a bill introduced by Senator Strom Thurmond, would require the Secretary of the Department of Veterans Affairs to construct a medical research center for the VA and the Medical University of South Carolina in Charleston, South Carolina. This research center would be constructed and equipped under a cost sharing agreement between the Department of Veterans Affairs, the President of the Medical University of South Carolina and the Governor of South Carolina. It is our understanding the Center will conduct medical research activities to include geriatrics, diabetes, heart disease, arthritis and connective tissue disorders. While the bill does provide for joint ownership, management and use of the medical research center of the three principals involved, the Secretary may include in any agreement terms and conditions which are necessary to protect the interests of the United States. The VFW views this legislation as beneficial to veterans and has no objection to its advancement.

S. 573, introduced by the Ranking Minority Member of the Committee as well as Senators Simpson and Jeffords, would provide for third-party reimbursement of the United States for the cost of health care and services furnished a service-connected disabled veteran by the VA for a nonservice-connected disability. Inasmuch as this reimbursement would not go directly to the VA, but, rather the U.S. Treasury and we can see no direct benefit to veterans, the VFW does not support the enactment of S. 573.

S. 574, entitled the "Veterans Health Care Program Improvements Amendments of 1989", was introduced by Mr. Murkowski as well as Mr. Simpson and Mr. Jeffords.

Section 4 of S. 574 provides that the Secretary may provide simians and dogs specially trained as assistive animals to certain veterans. Not later than October 1, 1992, the Secretary shall evaluate the implementation of the program and submit to the Committees on Veterans' Affairs a report on the effectiveness of the program.

While the VFW commends the Ranking Minority Member for his foresight in recognizing the benefit this program will have on veterans suffering from quadriplegia, we would prefer to have a bill requires the Secretary to implement this program.

Section 5 would repeal the authority of the VA to furnish tobacco products to veterans receiving hospital or domiciliary care. The Veterans of Foreign Wars recognizes the nationwide movement toward a smoke-free environment and we are aware of the VA's concern for a smoke-free environment within VA medical centers. While we acknowledge that problems associated with smoking have been well recognized for over 20 years and the evidence is continuously growing, we do not feel this requires action that would ignore the rights of individuals and overlook the needs of veterans served by VAMCs, especially those veterans housed in long-term care facilities. We must note tobacco products have yet to be declared illegal by the United States Congress and a prohabition on the sale of tobacco products is not in the foreseeable future.

Section 6 would provide for an extension until 1990 of the VA's authority to furnish respite care. Respite care allows the veteran to enjoy living with his or her family. At the same time, it allows the family to occasionally catch its breath from the great demands of geriatric care. The VFW fully supports this program and certainly supports its extension. However, we would prefer to see the respite care program made permanent.

Section 7 would provide non-institutional alternatives to nursing home care. The VFW is on record as supporitng alternatives to institutional care. We believe every effort should be made to keep the veteran in a family environment when possible. We believe this contributes to the veteran's well-being and should be encouraged. We, therefore, support section 7.

Section 8 would extend premium pay for certain nursing assistants. The VFW believes this action will improve the recruitment and retention of these individuals and also have a positive impact on the recruitment and retention of other health-care personnel such as registered nurses. This section would also waive the reduction in retired or retainer pay for registered nurses as is done for physicians. The VFW supports this provision.

S. 748, the "Department of Veterans Affairs Health Care Programs Extension Act of 1989", was introduced by the Chairman of the Senate Veterans' Affairs Committee by request. This bill would expand outpatient treatment; increase the dollar ceiling for outpatient dental care through private facilities; extends respite care services until September 30, 1991; and, authorizes an appropriation for the continuance of the home grant program. The VFW supports all of the provisions in S. 748.

S. 947, the "Veterans Health Care Personnel Act of 1989", was introduced by the Chairman of the Committee along with several members of the Committee. We commend the Chairman for recognizing and addressing the serious problems facing the VA in recruiting and retaining health-care personnel.

The VFW concurs with the concept that the VA take all necessary actions to establish and maintain competitive levels of pay for the cited selected health-care employees. We recognize pay scales vary from place to place throughout our nation and we also welcome the concept of merit pay--called "cash awards"--in the bill. The VFW has previously stated its strong support for expanding VA's authority to make an exception to the title 5 provisions reducing the amount of retirement or retainer pay of a retired member of the uniformed services which is presently limited to physicians to include other employees within the health services and research administrataion career speciality fields.

Again, the VFW commends the Chairman for his efforts in not only increasing compensation for these highly dedicated employees but attempting to make the VA a more attractive place to work.

Mr. Chairman, this concludes my statement and at this time I would be happy to respond to questions you may have. Thank you.

Vietnam Veterans of America, Inc
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Suite 700
Washington, DC 20009-1125

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STATEMENT OF
VIETNAM VETERANS OF AMERICA, INC.

Presented By

THOMAS A. SHERWOOD
DIRECTOR OF HEALTH POLICY AND PLANNING

before the

SENATE COMMITTEE ON VETERANS AFFAIRS

on

HEALTH CARE LEGISLATION

MAY 18, 1989

Mr. Chairman and members of the Committee, the Vietnam Veterans of America (VVA) appreciates this opportunity to present its views on health care which at this time excludes legislation on mental health which will be addressed in the June 14, 1989 hearings before this Committee.

With regard to S-13: Veterans Benefit and Health Care Act of 1989, we would stress relative to section 225: Development of recommended legislation for the elimination of inconsistencies in certain veterans benefit laws, the need for input from the Veteran Service Organization (which, of course, includes VVA) especially regarding section 612 of title 38 of the United States Code.

With regard to S-165: Construct a medical research center for the Department of Veterans Affairs (DVA) and the Medical University of South Carolina in Charleston, S.C., we do express some concern. In terms of the veteran patient, is there a demonstrated need for this project? How will veterans be specifically served by this joint venture for which the taxpayer will have to pay in a time of severe budget constraints and DVA budget shortfalls? What will be the name of this medical research center? In addition to the 12 million dollar up front cost to the DVA, have recurrent costs relative to staff, supplies, equipment, etc. been taken into account? Have the necessary dollar commitments been obtained from the State and the medical school? Have the necessary feasibility studies been done at least relative to arrangement to ownership, management, joint operations, and specific responsibilities? What impact will be had on the project if for Fiscal Year 1991 or beyond the VA finds it cannot continue funding the venture.

We recognize the value of such projects relative to local economies as well as their value to the overall economy of this country. But we need to be assured that veteran needs come first and that the DVA is not involved in ventures they pay for while at the same time are without meaningful and significant control in the interest of the veteran for whom the DVA exists.

With regard to S-573: To provide for third-party reimbursement to the United States for costs of health care and services furnished a service connected disabled veteran by the Department of Veterans Affairs (DVA) for a non - service connected disability, we do express some concern.

VVA needs to be assured that the veteran will not be inconvenienced regarding the provision of health care services if the DVA and third party payor are involved in attempting to resolve administrative problems that may surface regarding contract and administrative arrangements.

VVA recommends that all veterans, regardless of service connection, who are insured by third party carriers be eligible regarding this legislative proposal.

With regard to S-899: To authorize the Secretary of Veterans' Affairs to establish and conduct, for five years, a leave sharing program for medical emergencies of employees of the Department of Veterans' Affairs who are subject to section 4108 of title 38, United States Code, and S-900: To extend for one year the authorization of the Department of Veterans Affairs to furnish respite care to certain chronically ill veterans and the due date for a report on the results of an evaluation of furnishing such care, VVA extends its support.

With regard to S-947: A bill to improve conditions of employment for employees of the Veterans Health Service and Research Administration (VHS & RA) and for other purposes - this bill called "Veterans Health Care Personnel Act of 1989," we extend our support. This support is not given to the exclusion of any other proposals provided in bills on this subject in the House of Representatives. Both proposals are most worthwhile in our judgement.

Title I of S-947 appears to relate to the Wage Grade Schedules (WGS) already in existence. WGS allows the DVA to compensate employees at hourly rates which are, in part, determined by negotiated contracts between labor and management systems outside of the DVA in the community in which the DVA exists. The VA medical center director is involved in transmitting those salary changes to DVA central office as the salaries go into effect for wage grade earners. We support that concept.

Before closing, we would take this time to remind this Committee of the Management Efficiency Pilot Program which was established in law. As you may recall, five DVA medical centers in this program are being administered with "limited" DVACO control as a part of a time limited project to determine the value associated with decentralizing medical centers.

The medical centers involved in the program are the DVAMCs in Boise, Idaho, Indianapolis, Indiana, Long Beach, California, Minneapolis, Minnesota, and Richmond, Virginia. Also, on the Veterans Benefits Administration's side of the Department five regional offices, and the Austin, Texas Processing Center are involved in a Management Efficiency Pilot Program (MEPP). The Veterans Health Services and Research Administration's MEP Program started in Fiscal Year 1987 and is due to terminate at the end of Fiscal Year 1990. In spite of the requirement that at the end of the first two years there would be an evaluation generated, to date no such evaluation has taken place. There appears to be no support for this program at the Chief Medical Director's level, no meaningful meetings taking place involving any feedback or reports of progress. Apparently, Veterans Benefits Administration relative to their MEP Program have been much more interactive and successful.

Unfortunately, several limitations existed in the project from the begining such as revenues generated by the medical centers not reverting back to the center, Resource Allocation Methodological restraints, decentralization to the medical centers' personnel ceiling controls with limited dollar flexibility, etc. In view of the new Department of Veterans' Affairs, we think it would be valuable if the progress and current assessment of the MEPP is reported. The time is now to get this program back on track.

Finally, Mr. Chairman, none of the legislation under consideration at today's hearing addresses the issue of extending the DVA's authority to provide health care to Agent Orange or radiation exposed veterans. The existing authority which places these veterans in Category "A" status, as we understand it, is currently scheduled to expire at the conclusion of the fiscal year. We strongly urge this committee to extend this authority without delay.

Once again, we thank you for this opportunity to share our views.

Department of Medicine
and Surgery
Washington D.C. 20420

Veterans
Administration

JUN 2 2 1989

In Reply Refer To: 10A1A

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

During the Committee's May 18, 1989, hearing, a copy of the report on the VA Rehabilitation Research and Development Service's evaluation of providing monkey helpers to aid quadriplegic veterans was requested.

A copy of that report and the results of a survey of veteran interest in this program is enclosed. The Department is currently reviewing this report to determine further actions to be taken.

Sincerely yours,

Arthur J. Lewis. MD
For John A. Gronvall, M.D.
Chief Medical Director

Enclosure

"America is #1—Thanks to our Veterans"

SUMMARY REPORT OF SURVEY TO DETERMINE VETERANS' INTEREST IN "CAPUCHIN MONKEYS AS AIDS FOR THE SEVERELY DISABLED"

Introduction

The Rehabilitation Research and Development (Rehab R&D) Service of the Department of Veterans Affairs (VA) has provided funding for the project, "Capuchin Monkeys as Aids for the Severely Disabled," since 1982.

During that time, the Rehab R&D Service has provided approximately $900,000 to this effort in order to produce a monkey-helper which could assist mid- and high-level quadriplegic veterans.

In order to determine the potential need to provide such a monkey-helper as a care-provider, a survey was conducted in March 1989. The survey was developed, through a joint effort, by the Rehab R&D Service, M. J. Willard, Ed.D., principal investigator, and Boston University, and was mailed to 1,000 quadriplegic veterans (500 service-connected and 500 nonservice-connected). The results were tabulated and analyzed by an independent consultant.

Results

The survey was responded to by 151 veterans, both service- and nonservice-connected.

Of the 151 questionnaires returned, the results were as follows. To the essential question of "considering both positive and negative traits of monkeys, would you want a monkey-helper?"

Yes	29
No	102
Maybe	20

In the "yes" category, there were:

Male	26
Female	3

However, these were not all unequivocal "yeses;" rather, many related to conditional/trial acceptance and need for more support and information.

In the "maybe" category were the conditional/provisional statements that usually reflected or stated "not now, but maybe later."

Approximately 4% stated they worked; however, none of the "yes" responded that they worked.

The average level of injury was C-6 with ranges from C-1 to T-1. The average number of hours spent in a wheelchair per respondent was six-eight hours.

Eighty percent (80%) of respondents live at home with a spouse, 15% reside in a nursing home, and 5% are currently in a hospital (not determined whether intermediate medicine or spinal cord injury long-term care). Sixty-five percent (65%) have children in the residence and 55% have attendants also.

Respondents in the "no" and "maybe" categories found several areas of monkey-helper behavior and traits not acceptable. Of these unacceptable traits, respondents indicated more than one; therefore, the following percentages reflect the frequency of indication of an unacceptable trait.

		Percent
A.	Objections of family member(s)	85
B.	Objections from attendant	50
C.	Away from home	30
D.	Interfere with work	3
E.	Cost	5
F.	Don't want a dependent animal	65
G.	Animal traits and behaviors	70
H.	Sexuality of animals	45
I.	Other	25

Summary and Conclusion

Of the 151 questionnaires returned, there were 29 "yes," 102 "no," and 20 "maybe" responses. A review of those returned indicates two-thirds either did not complete the information requested or did not adequately and/or accurately fill in the necessary information. The population responding included males and females, most of whom did not work; most reside with a spouse, a child, another family member, a friend, or an assistant; and some list other pets as living in the household. A further review of the responses indicated that many considered obtaining a capuchin monkey to be in the "pet" area, while others had personal reservations as to the length of stay of a monkey. Objections from family members or an attendant were listed, as well as cost, undesirability of a dependent animal, and animal traits and behaviors.

Some veterans looked on the monkey as a temporary visitor which can be returned at any time; as a veteran's risks of physical-psycho-social conditions worsening increase, the concern for the monkey may become an issue, as it will when other children, family "live-ins," and additional pets are added to the monkey's environment.

Serious consideration must be given to the fact that 1,000 survey forms were sent out and 151 were returned, which would infer a lack of interest or ambivalence.

The research and development for the use of capuchin monkeys as aids for the severely disabled have been funded by VA since 1982 and several national publications and newspaper articles have featured this project. In an effort to determine both the effectiveness of the research and development and forecast the need for this type of care-giver, a retrospective evaluation to determine the effectiveness of the monkeys trained and placed in patient homes was completed. This feasibility/needs analysis indicated that the interest is not great in the total number surveyed; those interested were positive in their approach and realistic in expectation as to the role the monkey would play in care delivery.

AN EVALUATION OF CAPUCHIN MONKEYS TRAINED TO HELP SEVERELY DISABLED INDIVIDUALS

Prepared by the
Rehabilitation Research and Development Evaluation Unit
Department of Veterans Affairs
Baltimore, MD 21202
MAY 31, 1989

AN EVALUATION OF CAPUCHIN MONKEYS AS HELPERS FOR SEVERELY DISABLED INDIVIDUALS

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Abstract

The results of ten years (seven of these funded by VA at a cost of approximately $900,000) of research and development activities concerning the use of monkey helpers to quadriplegics were evaluated by assessing current placements. Helping Hands, Inc. reported that a total of 14 monkey helpers have been placed.

In this evaluation, a detailed retrospective study was made of nine of the ten monkeys currently placed as helpers. One current placement was considered geographically too distant to be included in the study. An experienced therapist conducted on site interviews with the owners of eight of the currently placed monkeys and the monkeys were directly observed performing their assistive tasks. One owner of a currently placed monkey was interviewed in the hospital.

In the four placements no longer active, telephone interviews were conducted with the disabled persons in two cases and on site was conducted with the wife of the disabled person now deceased in one case.

Helping Hands Inc., Boston, MA, was visited as well as the monkey breeding colony in Disney World. Additionally, the interviewers visited the homes of 3 of the 89 foster parents reported by Helping Hands as raising monkeys to be trained as helpers.

The evaluation provided sufficient positive findings that monkey helpers are useful, effective and acceptable.

The research, development and evaluation phases of this project are completed. The evaluation of the monkeys placed was found to be satisfactory. If enabling legislation is passed authorizing VA to provide monkey helpers to quadriplegic veterans, Helping Hands, Inc., would be considered a vendor providing the monkey helpers and all necessary related services including placement and follow-up as required.

AN EVALUATION OF CAPUCHIN MONKEYS TRAINED TO HELP DISABLED INDIVIDUALS

I. Introduction

Since 1982, the Rehabilitation Research and Development Service of the Department of Veterans Affairs (VA) has funded research on the use of capuchin monkeys as aides to disabled individuals. This research has been conducted jointly by Helping Hands, Inc. and Boston University under contract to the Department of Veterans Affairs.

This report covers an assessment conducted in February and March 1989 to determine the activities, effectiveness, advantages and disadvantages exhibited by the capuchin monkeys currently placed to help disabled persons.

II. Methodology

Helping Hands, Inc. identified fourteen placements of monkey helpers. This report summarizes data from interviews conducted with nine disabled persons.

Eight of the nine active monkey placements were observed directly by an experienced therapist who interviewed the quadriplegic. One person was hospitalized and the interview was conducted in the hospital. The interviewer spent 3 1/2 or more hours at each of the interview sites.

The circumstances of the remaining five placements are summarized below:

> One visit was conducted with the spouse of a deceased veteran. The monkey was present on site during the interview but was awaiting reassignment. The wife reported that she and her husband were pleased with the monkey helper and that it had been possible for the veteran to be left alone for five to six hours with the monkey. Previously, she would not leave the veteran unattended. The interviewer observed that the monkey now responds to her verbal commands.
>
> Another visit was conducted with a quadriplegic and his father. This quadriplegic's monkey helper had been returned to Helping Hands, Inc. for reassignment. Both reported that for five months the monkey had been very helpful, but after the quadriplegic was bedridden and isolated for three months, the monkey responded to the father rather than the quadriplegic. This monkey was then returned to Helping Hands, Inc.

Telephone contact was made with one person who had received a monkey helper but subsequently returned it to Helping Hands. This monkey helper was reassigned to one of the paraplegics who was site visited in this study. The initial owner reported that for one year the monkey performed when requested and as needed. However, when the owner returned to work the monkey was left alone for too many hours during the day and it was felt that the monkey would better serve someone else.

One placement was made overseas and so was considered beyond the travel range for this evaluation.

One placement was discontinued because the individual suffered from cerebral palsy and lacked sufficient motor control to properly operate the monkey related equipment. The monkey helper was returned to Helping Hands, Inc.

III. Findings

A. Environment of the Monkey Helper

The monkey helpers in this evaluation were placed with six male and three female quadriplegics. Two of the quadriplegics, both males, were veterans. One quadriplegic's disability was from muscular dystrophy, eight were due to traumatic spinal cord injury.

Six of the disabled persons resided with a family member (four of these with a spouse), two in a resident home and one alone with a 24 hour attendant. Three had a part-time attendant and one, a full-time attendant. Five of the paraplegics had cats, dogs and a ferret, as pets, none of which appeared to pose problems for the monkey helper.

The family members universally accepted the presence of the monkey helper. Seven caregivers reported free time on a daily basis as a result of a few hours of assistance by the monkey helper. All nine of the disabled persons reported that the monkey helper was a pet/companion and aide.

B. Description of Monkey Helpers

The monkey helpers in this study have been placed for varying periods of time (see Table 1). Three of the monkeys (Jeep, Cleo, and Maggie) have been placed for less than one year, whereas, Hellion has been placed for about ten years.

Capuchin monkeys live to be 30 years of age on an average. The monkey helpers range in age from 6 to 20 years old. The productive life expectancy of the Capuchin is estimated to be twenty years.

C. Activities Performed

All monkeys are trained in a basic repertoire of 60 assistive tasks (see Appendix A). Although the monkey helper arrives at the home of the disabled person with this training, it is the particular needs of the quadriplegic that will determine what specific activities the monkey will ultimately perform.

The monkey helpers were observed to perform about 58% of the tasks which they learned at Helping Hands, Inc. Additionally, they are able to perform other tasks not addressed in basic training, e.g., turning on/off a computer, television, radio and lights; repositioning foot on footrest; pushing buttons on a telephone; and turning a faucet on and off.

The type of tasks requested of the monkey helper varied according to the individual's needs. All individuals reported complete satisfaction with the monkey helper's response, performance and behavior.

Each person interviewed was specific that the monkey now accomplishes all of the requested tasks by responding to verbal commands; the laser pointer was used in a demonstration only and there was no need for negative shock reinforcement. The shock pack, a device built into a belt which the monkey wears and which allows the trainer to sound a warning tone or give the monkey a 0.5 second shock, was reported as being used only during the initial in-home orientation or in training of new tasks.

A review of the tasks performed by the monkey helper indicates that the longer the monkey lives with the disabled person, the greater the number of tasks it performed (see Table 1).

Table 1

Number of Assistive Tasks Performed by a Monkey Helper (Reported to and Observed by Interviewer)

Name of Monkey	Number of Years With Disabled Person	Number of Tasks
Hellion	10.0	28
Freeway	8.0	24
Su Su	6.5	28
Henri	6.0	28
Jo	5.0	27
Peepers	1.5	23
Cleo	0.5	15
Jeep (Reassignment)	0.5	6
Maggie	0.4	23

The assistive tasks observed by the interviewer as they were being performed by a monkey helper are listed in Appendix B. These tasks can be sorted into four categories: feeding, fetching, manipulating objects and personal care. The monkey helpers all responded very reliably to verbal commands and to the laser pointer in a demonstration. The monkeys did what they were asked to do by their owner.

The survey results show that the monkey has increased the quadriplegic's independence of human assistance. This is explicitly reflected by the increased time that a quadriplegic spends without a caregiver since the monkey placement (see Table 2).

Table 2

Hours a Quadriplegic Spends Without a Caregiver

	Without-Monkey Helper	With A Monkey Helper
Average Hours	0.4 hours	5.9 hours
Range for 9 Quads	0 to 3 hours	1 to 15 hours

The flexibility of the monkey is important. The monkey can accompany its owner to perform requested tasks anywhere in the house and even travel with the disabled person. The demonstrated ability to learn additional tasks not taught in basic training, e.g., foot positioning, expands the utility of these helpers.

A very important aspect clearly experienced by all persons interviewed was the relationship which developed between the individual and the monkey helper. In all cases this "bonding" means a lot to the person who views the monkey as a companion/pet in addition to functioning as an aide.

D. Acceptability

A number of areas were reviewed regarding the acceptability of a monkey helper. The following potential problem areas were explored by the interviewer but produced no unfavorable information.

Aggressive or undesirable monkey helper behavior: All interviewees identified their monkey's behavior as acceptable and none reported any incident of unacceptable behavior.

Care of monkey: The feeding, caging, grooming, etc. of the monkey was acceptable to the family, and/or attendant.

Health care of monkey: The required medical care of all monkey placements was reported as minimum to non-existent. Two instances of colds were reported which in coordination with Helping Hands, Inc. were treated locally in a routine manner. In view of the length of time (5 to 10 years), the monkeys have lived with the disabled person there appear to be no special medical problems or health care requirements. The eight monkeys visited appeared healthy and clean. No odors were detected in the house.

Matching of monkey with disabled: The screening and pre-placement work-up established by Helping Hands, Inc. appear to be effective. All currently placed monkeys are functioning well. In the terminated placements, the monkeys were removed to respond to the changing needs of the disabled.

Supply of monkey helpers: Helping Hands, Inc. has developed a system to breed, socialize and train monkeys as helpers. The span of 4 to 5 years from birth to completion of training of each monkey affects the supply of monkey helpers on an annual basis. Helping Hands, Inc. reports 89 monkeys are currently in foster homes as part of the pre-placement process. Fifteen monkeys were in training at Helping Hands, Inc. at the time of this evaluation.

Care of monkey helper in absence of disabled person: Absence of the disabled person, either for short term hospitalization or employment presents problems. The monkey helper, for example: regresses in terms of learned behavior; and may transfer allegiance or response patterns to someone else in the household. Helping Hands, as a part of its placement criteria makes a systematic determination on the disposition of the monkey helper should absence occur.

IV. Conclusions

An intensive on site evaluation was conducted of nine carefully selected individuals who currently have a monkey helper provided through a project, seven years of which were funded by VA at a cost of approximately $900,000.

Monkeys can be taught to perform a variety of useful tasks for disabled individuals. By performing these tasks, the monkey helper offers a degree of freedom for a caregiver. A monkey helper also can provide the opportunity for the disabled person to be without a caregiver for some period of time. The performance of assistive tasks is a significant positive contribution to enable a disabled individual to become more independent. Sufficient positive results were obtained in this evaluation to conclude that monkey helpers work, are useful and accepted.

The monkey helper was positively accepted in the household of each of the nine disabled individuals and by all types of caregivers, friends, family and paid attendants. Monkey helpers exhibited a positive behavior and became an accepted member of the household.

The research, development and evaluation phases of this project are completed. The evaluation of the monkeys placed was found to be satisfactory. If enabling legislation is passed authorizing VA to provide monkey helpers to quadriplegic veterans, Helping Hands, Inc., would be considered a vendor providing the monkey helpers and all necessary related services including placement and follow-up as required

APPENDIX A

BASIC REPERTOIRE OF TASKS MONKEY HELPERS ARE TRAINED TO PERFORM BY HELPING HANDS, INC.

Feeding

Hold sandwich
Spoon feed meals
Feed snack

Personal Care

Wipe face
Scratch face with cloth
Put on eye glasses
Take off eye glasses

Fetching

Retrieve mouth stick
Retrieve bottle
Retrieve cup
Retrieve plate
Lift small items from floor
Lift small items from table
Place book for reading
Retrieve splint

Manipulating Objects

Reposition quad's arm
Open cage door
Close cage door
Load floppy disc
Pull cords
Position remote controls
Turn book pages
Position computer paper

Manipulating Objects

Open bottle cap
Close bottle cap
Place drinking straw
Remove drinking straw
Open small refrigerator door
Close small refrigerator door
Place sandwich in holder
Hold cup
Hold plate
Hold bottle
Open oven door (cold)
Close oven door (cold)
Open food container
Close food container
Open cartons
Close cartons
Vacuum floor
Open doors
Close doors
Lock doors
Unlock doors
Open drawers
Close drawers
Open cabinet
Close cabinet
Empty trash
Clean table top spills
Open curtains
Position "J" stick
Load VCR cassette
Unload VCR cassette
Load audio cassette
Unload audio cassette
Position sip and puff unit
Position small appliances
Change floppy disk
Position disk for CD player

APPENDIX B

ASSISTIVE TASKS OBSERVED IN THIS STUDY AS BEING PERFORMED BY A MONKEY HELPER

Feeding

Spoon feed meals
Feed snacks
Hold sandwich

Personal Care

Wipe quad's face
Scratch quad's face

Fetching

Retrieve bottle
Retrieve cup
Retrieve plate
Retrieve mouth stick
Lift small items from floor
Lift small items from table
Place books for reading

Manipulating Objects

Wipe table top
*Wipe lap tray
Place straw
Remove straw
Place sandwich holder
Remove bottle top
Replace bottle top
Hold Bottle
Hold cup
Position "J" stick
Open food container
Close food container
Open small refrigerator
Close small refrigerator
*Turn on computer
*Turn off computer
Open cartons
Close cartons
*Turn on lights
*Turn-off lights
Lock door
Unlock door
*Turn-on radio
*Turn-off radio
Load audio cassette
Unload audio cassette
Load video cassette
Unload video cassette
Position quad's arms
*Position foot on footrest
Position sip and puff unit
*Turn-on faucet
*Turn-off faucet
*Push buttons on telephone

* Not included in basic repertoire training

American Association for Marriage and Family Therapy

STATEMENT OF MARK R. GINSBERG, EXECUTIVE DIRECTOR
AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY
REGARDING THE RECRUITMENT AND RETENTION OF CERTAIN
HEALTH AND MENTAL HEALTH CARE PERSONNEL
BY THE DEPARTMENT OF VETERANS' AFFAIRS
SUBMITTED TO THE SENATE VETERANS' AFFAIRS COMMITTEE
MAY 18, 1989

Mr. Chairman and distinguished members of the Committee, I am Mark R. Ginsberg, Ph.D., the Executive Director of the American Association for Marriage and Family Therapy (AAMFT). My statement is submitted on behalf of the 16,000 members of AAMFT, the national professional association of qualified practitioners of marriage and family therapy.

My statement also is endorsed by the California Association of Marriage and Family Therapists (CAMFT), a separate organization representing the interests of more than 17,000 licensed practitioners in the state of California, with which AAMFT has a close working relationship.

I appreciate having this opportunity to comment on certain aspects of the personnel shortage facing the Department of Veterans' Affairs (VA) health care system and recruitment and retention efforts aimed at qualified health and mental health care professionals. This problem has reached a critical stage in recent months, especially when viewed in the broader context of federal budget constraints.

There are two factors crucial to recruitment and retention of health and mental health care personnel at the Department of Veterans' Affairs:

1) the Department must broaden its recruitment efforts to include health and mental health care professionals who meet stringent educational and training standards that are appropriate to the services provided to veterans.

2) the Department must provide its health and mental health care professionals compensation and career opportunities comparable to those available in the private sector, if professionals are to be encouraged to make careers of working with veterans.

Within the broader context of VA personnel matters, I would like to address my comments specifically to the exclusion of Marriage and Family Therapists as providers of mental health care within the Department of Veterans' Affairs health care system, and the potential impact of this omission on the VA personnel shortage and on the provision of services.

The American Association for Marriage and Family Therapy (AAMFT) receives repeated inquiries from well-trained Marriage and Family Therapists around the country who are interested in VA career opportunities. These inquiries indicate a consistent source of well-qualified professionals who could help to alleviate a shortage of mental health professionals within the VA hospital system.

In addition, Department officials acknowledge that marriage and family therapy is now provided actively to veterans' and their families by mental health professionals already employed by the VA hospital system -- psychiatrists, psychologists, social workers and psychiatric nurses. However, there is no indication of whether these professionals have received appropriate training in family systems theory and other components necessary for optimal delivery of this important service.

We know, too, that the Vietnam Veterans' Readjustment Counseling Centers have more latitude than the hospital system in hiring mental health professionals and, as a result, they regularly and actively recruit marriage and family therapists for counseling teams.

Despite these indications of the VA's need for well-qualified personnel, the Department's promotion of this effective service, interest by well-qualified professionals in VA employment, and potential impact of inappropriate training on beneficiaries, Marriage and Family Therapists continue to be barred from VA employment for one simple reason: there is no General Schedule series for these professionals under Title V of the Federal Civil Service System nor is there a professional designation under Title 38, the Department of Veterans' Affairs internal hiring system. Without either mechanism, Marriage and Family Therapists who are trained specifically to provide marriage and family therapy, a recognized VA service, are frozen out of career opportunities under the Veterans' Affairs hospital-based health care system.

AAMFT believes that the omission of a class of well-trained professionals can only serve to exacerbate the dire personnel crisis facing the Department. It may also result in less than the highest quality of services being provided to veterans and their families.

Definition of Marriage and Family Therapy

Marriage and Family Therapy is the diagnosis and treatment of mental and nervous disorders within the context of marital and family systems. The practice of Marriage and Family Therapy, whether by marriage and family therapists or other appropriately trained mental health professionals, involves the application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed mental and nervous disorders.

As a model for mental health treatment, Marriage and Family Therapy generally regards psychopathology and dysfunction as related to phenomena of the family system, rather than from intrapsychic problems or conflicts. It is characterized by the view that an individual experiencing the symptoms of a mental or nervous disorder is part of a larger system and, regardless of the eventual intervention modality, that larger system is essential both in evaluating the etiology of the symptom and in treatment. Consequently, treatment from a Marriage and Family Therapy perspective involves, among other goals, the modification of the behaviors and the structures of the family system. Therefore, treatment usually involves intervention with all or some of the family's members.

Although a relatively young profession, Marriage and Family Therapists are growing rapidly in number and quickly have become an integral component of our health and mental health care delivery system. The development and widespread acceptance among researchers and clinicians of Marriage and Family Therapy as a critical modality for intervening with an array of mental and nervous disorders has helped to foster the rapid evolution of the field. It is rare today to treat either inpatients or outpatients without attention to the dynamics of the family system.

For example, marriage and family therapy is considered an essential treatment for substance abuse disorders and chemical dependency, a very prevalent and costly tandem of problems in our society and one faced by many Vietnam-era and other veterans. In addition, the treatment of major mental illnesses, including schizophrenia and other forms of psychosis, and other forms of psychopathology, including Post-Traumatic Stress Disorder (PTSD), nearly always include family intervention in treatment. A large research literature exists documenting the effectiveness of Marriage and Family Therapy as an appropriate and necessary intervention for these and many other mental and nervous disorders. It is my understanding that Department of Veterans' Affairs mental health care officials share this view.

Marriage and Family Therapists are well-trained. As the national credentialing body for Marriage and Family Therapists, AAMFT requires that its members meet rigorous educational and training standards which have been established as entry criteria into the profession of Marriage and Family Therapy. Clinical Members of AAMFT have completed specific postgraduate training in Marital and Family Therapy as well as extensive supervised clinical practice with couples and families.

At present, 18 states license or certify Marriage and Family Therapists: California; Arizona; Colorado; Connecticut; Florida; Georgia; Massachusetts; Michigan; Minnesota; Nevada; New Jersey; North Carolina; Rhode Island; South Carolina; Tennessee; Utah; Washington and Wyoming. In the past two years, seven states have enacted regulatory laws for Marriage and Family Therapists. This is evidence of a powerful trend in state legislatures to recognize the special training and skills of these mental health professionals.

Recommendations

In making the following recommendations to the Committee, I would like to commend the Department of Veterans' Affairs for its recognition of the importance of the family system in the treatment of mental and nervous disorders. In doing so, the Department joins the U.S. Department of Education, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and eighteen states in recognizing the delivery of state-of-theart care to individuals and families in need of mental health services.

In addition, it is not AAMFT's intention that other qualified mental health professionals be prohibited from providing marriage and family therapy services to veterans' and their families. In fact, AAMFT encourages the provision of this important service by other mental health professionals, as long as they have received specific training in Marriage and Family Therapy. Such training requirements are necessary to ensure the optimal provision of services to veteran's and their families.

AAMFT recommends that the Committee take the following actions to rectify the glaring omission of a class of well-trained professionals who seek to serve Veterans in need, ensure the optimal provision of care, and alleviate the shortage of mental health personnel at the Department of Veterans' Affairs:

1) Amend S. 947, the Veterans' Health-Care Personnel Act, to create a designation for Marriage and Family Therapists under Title 38, as has

already been done for other health care personnel (e.g. psychiatrists and nurses). To ensure that optimal provision of services and professional accountability, AAMFT also recommends that the amendment include the development of an appropriate administrative structure for Marriage and Family Therapy within the Department of Veterans' Affairs, parallel to existing structures for psychiatry, psychology, social work, and psychiatric nursing;

2) Direct the Office of Personnel Management (OPM) to take administrative action to create a professional designation for Marriage and Family Therapists under Title V of the Federal Civil Service System. Should the Committee opt for this action, AAMFT recommends the enactment of complementary legislation to develop an appropriate administrative structure for Marriage and Family Therapy within the Department of Veterans' Affairs, parallel to existing structures for psychiatry, psychology, social work, and psychiatric nursing. This complementary action is necessary to ensure optimal provision of services and professional accountability.

3) Require the Department of Veterans' Affairs to develop and implement stringent educational and training standards for all mental health professionals, including Marriage and Family Therapists, who provide Marriage and Family Therapy services to veterans. This is necessary to ensure that veterans and their families receive the highest quality services.

AAMFT believes that these actions will assist in recruitment and retention efforts at the Department of Veterans' Affairs, will ensure high quality services for veterans, and will bring the Department up-to-date with developments in the private marketplace.

On behalf of the American Association for Marriage and Family Therapy, I appreciate having this opportunity to submit comments on this important issue.

AARC
AMERICAN ASSOCIATION FOR RESPIRATORY CARE
11030 Ables Lane, Dallas, TX 75229, 214/243-2272, Fax 214/484-2720

WRITTEN TESTIMONY SUBMITTED TO THE SENATE
VETERAN'S AFFAIRS COMMITEE BY:

THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE (AARC)

THE VETERAN'S HEALTH CARE PERSONNEL ACT OF 1989

MAY 18, 1989

TECHNICAL ASSISTANCE PROVIDED BY: ERIC GROSMAIRE, MS, RRT

Sponsored by American College of Chest Physicians, the American Society of Anesthesiologists, and the American Thoracic Society

As President of the American Association for Respiratory Care (AARC), a 27,000 member professional Association comprised of respiratory care practitioners from across the country, I welcome the opportunity to submit testimony on The Veteran's Health Care Personnel Act of 1989. Respiratory care is a health care specialty performed under the direction of a qualified medical director for the assessment, treatment, management, diagnostic evaluation, and care of patients with deficiencies, abnormalities, and diseases of the cardiopulmonary system. The profession of respiratory care is facing the same manpower shortages affecting other health care personnel in this country. The recent Institute of Medicine's report on health manpower predicts that by the year 2,000 the demand for respiratory care practitioners will exceed the supply of personnel by thirty-four percent. Nowhere is this strain on manpower felt more acutely than in the Veteran's Administration health care system. Simply stated, VA hospitals cannot compete with local hospitals for the limited supply of qualified respiratory care personnel. The result is that positions remain unfilled, staff is stretched to the limit, and often patients simply do not receive the necessary respiratory care.

The AARC believes that The Veteran's Health Care Personnel Act of 1989 forcefully addresses the severe manpower shortage problem facing the VA health system, but it only directly addresses the problem for a limited group of professionals. We agree that the first step in rectifying disparities between the VA and private hospitals is to have the Secretary survey the local labor market to determine local salaries and adjust the VA wages accordingly. However, as respiratory care practitioners, we are gravely concerned that by allowing the Secretary the option to raise allied health practitioner wages, the so-called "hybrid" class, we fear the option will not be exercised and the situation of the VA allied health practitioner will remain the same. The framework of the bill is excellent, but the beneficiaries of the solution to the manpower shortage are extremely limited. Manpower shortages are simply not limited to the nursing profession in the VA health system. If this limitation for the benefits of this bill remain unchanged, few of the remaining crucial provisions of the bill will have any impact on allied health.

To document the problems that respiratory care professionals are having in the VA, the following examples will be useful in your deliberations:

> From the Tampa, Florida VA: Ten percent of the staff positions are vacant. One position is actually filled by two part-time students because no respiratory care practitioner wishes to take the job full-time. Another point made by the Tampa VA is that, based on an independent agency's wage survey of the Tampa area, this VA's Director and Assistant Director of Respiratory Care are the lowest paid in the county for these positions ($2,000 - 5,000 less).
>
> From the Yuma, Arizona VA: This respiratory department received two responses to an ad placed for full-time equivalent positions. When the individuals were told what the starting salary would be, both refused even to apply for the respiratory care position. Furthermore, this respiratory care department director indicated that his salary is $6,000 less than the average respiratory therapy director ($35,900) as calculated by a **Health Administration Today** wage survey (see attachment #1).

> From the Coatesville, Pennsylvania VA: "As Chief of the Respiratory Therapy Department at the Coatesville, PA, Veteran's Administration Hospital, I am experiencing a recruitment and retention problem due to current VA salaries for technicians and therapists remaining far below average for this geographical area. As a result, our veterans are not receiving the care they deserve due to this serious shortage of qualified personnel."
>
> From the Martinez, California VA: "Understaffing - currently our FTE's are at 6.0, but we should be staffed at 10.0. We are unable to cover ICU/CCU on the night and evening shifts during the week, and especially on the weekends. Salary - because of our lack of comparable salaries with surrounding hospitals, it is difficult to recruit licensed, qualified people. Shift Differentials, Overtime, Compensation Time, Etc. - We are often asked to stay over or help cover a vacant shift, but we are unable to because we do not get adequate compensation and no overtime. We do not receive a comparable weekend differential as the nursing staff does."
>
> From the Veteran's Administration Medical Center in Phoenix, AZ: The Respiratory Care Director writes, "Last year, several employees resigned to accept positions at private facilities or with respiratory pool organizations for better salaries and flexible working hours. Recruitment to fill these vacancies evolved into in an extremely critical situation. It became difficult to recruit competent, credentialed individuals who were willing to accept respiratory care positions at the salaries offered by the Veteran's Administration Medical Center."
>
> From the VA Medical Center in Fresno, CA: The Director of Respiratory Care writes, "Recruitment of skilled respiratory personnel is practically nil in this area. Salaries are running in the thousands above the GS schedule. Even one-year graduate entry-level practitioners are bringing in $22,00 per year to start elsewhere in comparison to $15,738 which is mandated by personnel interpretation of the GS schedule. Patients in our hopsital are not receiving physician ordered medications and other respiratory care procedures which are of a critical nature because of lack of staff. Presently, I am down only one position, but my staff has been cut back two positions because of budget constraints. It is vital that the one position be filled with an experienced therapist, as the person will often work without supervision. I have recruited for almost four months."
>
> From the Palo Alto, California VA: "During the past two years, we have hired only three R.T. graduates. Of these three, we have retained 0. We currently have two vacant positions and are unable to hire qualified help."

Attachment #2 provides even more evidence that recruiting qualified respiratory care practitioners is extremely difficult, if not almost impossible. This information was provided by the Tampa VA and is indicative of the widespread recruiting problems.

Retention of qualified personnel is just as severe a problem as recruiting personnel. A VA Department Head writes, "Once these new hires have become 'experienced,' they can present themselves to local, private sector hospitals as being experienced and so be recruited for a higher salary and a better benefit package. We are then left with an empty position and having to start all over again. This exact scenario just happened to us recently. We hired a student and he gained about six months experience with us, along with being promoted to a GS-5 level. At the end of that time, he went to a local, private sector hospital and received a starting salary equivalent to a GS-8."

The extraordinarily long wait before a wage increase is instituted simply drives prospective candidates away. It is not logical to expect a prospective candidate for hire at a VA hospital to readily agree that any salary increase will have to be delayed for two or three years as he/she moves through the GS system. As for premium pay and differentials, VA centers have an option to pay differentials on Saturday, and most choose only to pay that to nursing personnel. The Tampa VA reports that "The VA currently pays ten percent extra for any time worked between 6:00 p.m. and 6:00 a.m. This results in six hours of shift differential for both our evening and night shifts. Meanwhile, local hospitals are paying 10-20% extra for the evening shift and 15-25% extra for the night shift, and these differentials are for the entire eight hour shift, not just the six hours we receive."

Specifically, the AARC would like to comment on provisions of the bill using the recruitment and retention summary as a guide.

I. G. Parameters which will be established for wage comparison should not be so restrictive that the pool of hospitals to be compared will be limited to one or two. For example, only comparing hospitals which do open-heart surgeries would limit the hospitals for comparison.

II. Payment of overtime to nurses.
This provision appears to remove the overtime cap for nurses. The cap should be removed for all health care practitioners.

IV. Cash awards.
The provision should apply to all personnel.

VII. Reduction from 90 to 45 days for the consideration of a special pay rate request.
Again, allow this for all practitioners.

VIII. Allow scholarships for all individuals with associate degrees in the health field.

XIII. The donation of annual leave to assist individuals facing medical emergencies has been a compassionate and successful program. We request that the Committee consider allowing the donation of personnel's sick leave into the pool.

XIV. We believe any health professional who passes an accredited, certified specialty program and exam should be eligible for this bonus pay.

The AARC is very much aware of the fiscal constraints facing this nation. Yet the country and Congress have made a commitment to the nation's veterans. Veterans' health demands will increase, and veterans who suffer from such lung diseases as emphysema, asthma, bronchitis, and other chronic lung disorders will need care, and that care will be provided by respiratory care practitioners. The VA must reconcile its responsibility to veterans' health care and the reality of the medical manpower shortage. To provide quality health care will require experienced, qualified personnel, and the VA must become competitive in recruiting and retaining these health care providers.

We strongly support the concept and structure of the bill, but urge you not to limit the provisions to only one or two categories of health providers. Respiratory therapy is just as crucial and as life-sustaining as other more recognized professions, and our manpower shortages as documented above are just as grave.

1988 Average Base Salary and Salary "Movement" by Position
All Employees

Position Number	Title	1988 Average Salary	Change Since 1987
	General Executive		
011-001	CEO/Administrator II	$103,900	14.2%
011-002	CEO/Administrator I	85,700	7.6%
011-010	Associate Administrator	68,500	8.4%
011-011	Administrator for Medical Affairs	102,700	5.3%
011-012	Administrator for Facilities and Planning	59,000	6.9%
	Cross-Industry		
800-131	Director of Planning	$52,500	5.8%
800-210	Chief Financial Officer	63,000	6.9%
800-230	Controller	44,500	4.2%
800-250	Business Office Manager	31,700	4.3%
800-552	Director of Materials Management	36,000	5.6%
800-553	Director of Plant Engineering	39,800	6.1%
800-560	Director of Information Services	43,700	9.0%
800-565	Director of Security	31,900	5.3%
800-710	Director of Marketing and Business Development	49,200	3.6%
800-720	Director of Public Relations and Development	37,700	4.1%
800-740	Legal Counsel	64,100	7.0%
800-750	Director of Human Resources	43,800	6.6%
	Industry-Specific		
805-155	Director of Nursing Services	$51,100	20.5%
805-156	Assistant Director of Nursing Services	41,800	8.6%
805-160*	Director of Professional Services	56,000	—
805-165*	Director of Ancillary Services	52,100	—
805-170*	Director of Support Services	52,200	—
805-175	Operating Room Supervisor	37,600	9.9%
805-260	Director of Reimbursement Services	39,500	3.1%
805-270*	Director of Patient Accounts	36,600	—
805-300	Director of Food and Dietary Services	35,100	6.7%
805-370	Director of Medical Records	33,000	6.1%
805-375*	Director of Risk Management	38,600	—
805-380	Director of Quality Assurance	35,000	4.8%
805-382	Utilization Coordinator	30,500	5.5%
805-400	Director of Laboratory Services	40,200	5.8%
805-410	Director of Rehabilitation Services	45,400	2.3%
805-425	Director of Respiratory Services	35,900	5.6%
805-440	Director of Occupational Health	39,100	0.8%
805-450	Director of Social Services	34,100	4.9%
805-455	Director of Volunteer Services	27,400	2.6%
805-460	Director of Home Health	37,400	10.0%
805-465	Director of Ambulatory Care	43,700	-3.7%
805-475	Director of Physical Therapy	40,200	7.5%
805-476	Supervisor, Physical Therapy	35,600	8.2%
805-480	Director of Occupational Therapy	36,200	7.1%
805-481	Supervisor, Occupational Therapy	32,800	5.1%
805-485	Director of Speech Therapy	35,600	1.7%
805-486	Supervisor, Speech Therapy	32,900	10.4%
805-555	Director of Housekeeping	30,200	5.6%
805-600	Administrative Director of Radiology	36,700	6.1%
805-615	Director of Nuclear Medicine	39,100	0.0%
805-625	Director of Anesthesiology	54,400	-4.0%
805-721	Director of Fund Development	50,100	1.0%
805-770	Director of Education	37,300	6.0%
805-860	Director of Pharmacy	46,100	6.5%
805-861*	Assistant Director of Pharmacy	43,300	—
805-870*	Director of Pastoral Care	35,300	—
805-875*	Director of Biomedical Engineering	37,300	—
805-880*	Director of Library Services	29,900	—

* New position for 1988

—Cole Surveys, Inc.

Fig. 6 Average base salaries by position in 1988, and percent of change compared to Cole data for 1987. PT and OT positions all saw increases over 1987.

ATTACHMENT #2

EXAMPLES OF OUR DIFFICULTY IN RECRUITING AND RETAINING EXPERIENCED RESPIRATORY CARE PRACTITIONERS

Example 1.

Credential: CRTT
Experience: 3 years in the private sector
Results : This prospective candidate decided to hire on at The Tampa General Hospital (TGH) for the following reasons:

a. Relocation assistance money available from TGH
b. 12 hour shifts available
c. Better average salary

	Tampa VA	Tampa General
Base Salary =	$10.47/hr. (GS 7/6)	$10.41/hr.
Shift Differential =	10% X 6 hrs.	20% X 8 hrs.
Avg. 8 hr. salary =	11.26/hr.	12.49/hr.

We would have had to offer this candidate a GS-7/10 plus the 10% shift differential to come within 3 cents of the average TGH salary.

Example 2.

Credential: RRT
Experience: 7 years in the private sector
Results : This individual lives near the VA and wanted to find an employer who was closer to her home than her current one. She decided to stay with her current employer for the following reasons:

a. Lack of guaranteed tuition assistance
b. We offered this candidate a GS-8/8 to be competitive with her current salary; however, she receives a salary review every year with a 5-7% increase. In 14 months, she would have been at the same salary level that would have taken her 3 years to achieve at the VA (GS-8/9). Since I could not guarantee that she would receive a cost of living increase every year, I could only "guarantee" an increase in 3 years.

Example 3.

Credential: CRRT
Experience: Six months in the private sector and six months at this VA
Results : This excellent employee passed his CRTT credential and was given a GS-5 rating. However, Personnel told him that he would have to wait one year before he could be promoted to a GS-6, even though he had a total of one year's experience in the field. He went job hunting and found a local private

sector hospital which would give him the equivalent starting salary of a GS-8/1.

Example 4.

Credential: RRT

Experience: This individual had 12 year's experience in the field. She had held positions in the Florida Society for Respiratory Care. Her professional positions included both supervisory and management experience.

Results : At the time I talked to her, she was the manager of a department in a small community hospital which was probably going to be sold in the next few months. We would have had to offer her a GS-8/10 just to match her current salary. She declined to come to the VA, as that was as high as her salary could go.

Example 5.

Credential: RRT

Experience: This individual had a number of year's experience.

Results : We offered this individual a GS-8/6 (approximately $25,000/yr.). However, she had recently gotten a raise at Tampa General which put her at $28,000/yr. (GS-8/10). Since we could not offer her a higher salary without antagonizing the current staff, she declined to come to this VA.

Example 6.

Credential: RRT

Experience: 3 year's experience in the field

Results : This individual had been featured in local newspaper articles as having taken part in the delivery and post-partum care of a prematurely born chimpanzee at a local zoo. This was a result of his experience in neonatal intensive care at Tampa General Hospital, as well as being on their helicopter transport team. He was locked into twelve hour shifts and wanted to return to school to get a B.S. degree. The fact that we have eight hour shifts and are located across the street from the University of South Florida prompted him to apply here for a job. We offered him a GS-8/6 (which matched his current salary plus a 6% boost), and he accepted. However, when he returned to TGH to give his notice, his medical director changed his schedule, as well as offered him other inducements to stay, which he did.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
WRITTEN TESTIMONY
FOR THE
SENATE VETERANS AFFAIRS COMMITTEE
MAY 18, 1989

Mr. Chairman and members of the Committee, the American Association of Nurse Anesthetists (AANA) appreciates this opportunity to present written testimony regarding retention and recruitment of Certified Registered Nurse Anesthetists (CRNAs) in the Department of Veterans Affairs (DVA). Currently, of the 23,000 CRNAs in the United States, about 550 are employed by the Department of Veterans Affairs. We are very appreciate of your past and present efforts regarding these matters and commend you for introducing S.947, the Veterans Health Care Personnel Act, which addresses many of our concerns and proposes sound, viable solutions.

Shortage Of CRNAs In The Department Of Veterans Affairs

Like the private sector hospitals across the country, the Department of Veterans Affairs is experiencing problems in recruiting and retaining CRNAs. According to recent survey data, the DVA is currently experiencing close to a 15 percent shortage of CRNAs -- between 70 to 80 positions are unfilled.

More importantly, the number of vacancies over the last two years has doubled from 37 vacancies in 1987 to approximately 80 in 1988. It is anticipated that this situation will continue to worsen if the status quo is maintained. Among these vacancies, 67 percent were due to an exodus of CRNAs from the VA system.

Retention:

All hospitals, private and federal, are competing for the most experienced anesthesia health care providers. Maintaining a constant and reliable staff of hard to replace professionals is, or should be, a major goal for an employer seeking dependable, predictable and effective patient outcomes. It is also a more cost efficient managerial practice. The managerial and administrative aspects of employee retention, along with the costs involved in the revolving employee door syndrome, are well known and have been thoroughly explored by such experts as Peter Drucher, Fredrich Herzberg and Abraham Maslow, to mention a few. AANA survey data indicate that when CRNAs are seeking employment they are now looking at the total package of benefits, in addition to the base salary.

AANA Proposal 1: CRNA Pay

Entry level salaries in the DVA are non-competitive. We believe it is essential that a professional pay or bonus be instituted expeditiously for CRNAs if the shortage is to be addressed. Typically, the VA will offer an entry level CRNA an annual salary of $23,000 per year, or a Grade level 9-1. According to our data, in the private sector new graduates are being offered as much as $65,000 to start. This is a difference of over $42,000 a year, not including the benefit package. Obviously, there is a need to dramatically increase the pay at the low end of the spectrum.

In addition, experienced CRNAs are leaving the DVA for more competitive salaries in the private sector. Typically, a DVA CRNA does not get promoted as quickly as those in the private sector. As a result, there are disparities in income of as much as $37,000 per year for a CRNA with 10 years of experience.

In brief, we believe that the DVA pay package must be comparable to the private sector.

AANA Proposal 2: Improving Working Conditions

Overtime pay:

One of the biggest inequities within the VA pay system concerns overtime pay. Because of the nature of anesthesia, CRNAs are frequently required to work "on-call" or "overtime". However, unlike common practices elsewhere, which pay time and a half for overtime, the VA has capped the hourly wage rate for overtime at the Grade 11-1 level. As a result, some CRNAs make less per hour working overtime than they would have made if working straight time. As an example, a CRNA could receive about $23 per hour in base pay, but, when required to work overtime, the hourly wage drops to $19 per hour.

We believe that a special "overtime" or "on-call" salary level needs to be implemented. A time and one-half hourly wage rate for overtime can be an effective recruitment and retention benefit.

Upward Mobility program:

Another recruitment and retention tool we support involves instituting an "upward mobility" program that would encourage the CRNA to seek higher education and continuing education. Adequate financial support by the VA of educational endeavors would assist in the recruitment and retention efforts for CRNAs.

Currently, VA CRNAs can apply for authorized absence to attend continuing education programs, but seldom given little or no financial assistance. In sharp contrast, many facilities in the private sector allow CRNAs to attend continuing education programs by taking time off without pay, in addition to providing for educational program reimbursement.

In addition, unlike our other RN colleagues in the VA, CRNAs are not eligible for "upward mobility" educational funds by which an RN can seek a higher educational degree. Expanding this benefit to CRNAs would improve the VA's benefit package -- creating an attractive recruiting tool.

Improving Promotion Potential:

Special performance awards, designed to promote the competent and motivated employee, need to be generously implemented as a retention mechanism. Loyalty, hard work, increasing one's education and job knowledge, clinical performance, and increasing responsibilities all could be rewarded appropriately. These methods to promote job satisfaction would benefit both the employee and employer in the long term.

Recognizing employees' competencies by awarding a one, two or three step increase is another example of a reasonable and cost-effective retention tool. This reward has not been used consistently within the DVA; whereas, in some VA facilities, it is recognized as an excellent personnel tool. AANA supports a consistent and uniform personnel policy in all VA facilities.

Summary

Again, we commend the Chairman and this committee on its efforts to address these issues. We believe S.947 provides many of the solutions to recruitment and retention problems regarding CRNAs and therefore support wholeheartedly its enactment into law.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
AFFILIATED WITH THE AFL-CIO

JOHN N. STURDIVANT, NATIONAL PRESIDENT
ALLEN H. KAPLAN, NATIONAL SEC. TREAS.
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80 F STREET, N.W., WASHINGTON, D.C. 20001
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IN REPLY PLEASE REFER TO

May 18, 1989 **HAND DELIVERED**

Senator Alan Cranston, Chairman
Senate Veterans' Affairs Committee
U.S. Senate
SH-112
Washington, D.C. 20510

Dear Senator Cranston:

As per my conversation with your Veterans' Affairs Committee Staff, I ask that you include in the record of today's hearing, the statement of Ms. Vera Logan, President of American Federation of Government Employees Local 3943, 16397 Del Oro Circle, Huntington, California 92649.

Thank you for your consideration.

Sincerely,

Allynn Howe
Allynn Howe,
Legislative Representative

cc: NP John Sturdivant
Vera Logan

TO DO FOR ALL THAT WHICH NONE CAN DO FOR ONESELF

21

Greeting: Mr. Chairperson and Gentlemen of the Committee,

In this time of great adversity in recruiting and retaining nursing and other health care personnel **an internal mechanism** is needed for creating conditions of employment that are competitive and conducive to the recruitment and retention of the personnel needed to serve the veteran. The traditional mechanism is collective bargaining with appealing to FLRA when agreement can not be reached.

Congress never intended Title 38 employees to be excluded from Title 5 Chapter 71 bargaining rights. Title 5 makes particular reference to the V.A. in section 7103 (a)(3). It states, "For the purpose of this chapter -- agency means an Executive agency (including a nonappropriated fund instrumentality described in section 2105 (c) of this title and the Veterans Canteen Service, Veterans Administration ..... Until the passing of P.L. 96-330 in August 26, 1980 with the inclusion of language in section 4119 addressing the relationship of Title 38 and Title 5, management did not start challenging Title 38 employees bargaining rights any more than other employee bargaining groups.

Today new employee groups are being added to Title 38. Management is working to get more employee groups into Title 38. Invariably with the addition of each group, management tries to usurp rights the group enjoyed under Title 5 and Congress must then legislate clarification language into the law to preserve their Title 5 bargaining and other rights. These new Title 38 employee groups are being referred to as hybrid employees.

Additionally, in recent years fewer young people have been attracted to the nursing profession. High stress, heavy work loads, and trailing salaries have contributed to the unattractiveness of the profession. The VA NEEDS TO BE A LEADER, NOT A FOLLOWER, in improving nurses working conditions. The V.A. needs to look at every aspect of work dissatisfaction, address the problems - sometimes innovatively - and increase the attractiveness of the profession. If there is no improvement in working conditions, such as shift rotation, breaks, workloads etc., then V.A. must be prepared to OFFER THE TOP SALARY to attract nurses and other health care professionals. With ideal working conditions the V.A. can afford to OFFER SALARIES AMONG THE TOP to nurses and other health care professionals and still attract qualified personnel.

Ironically one of the Mission and Goals stated by the V.A. is "TO ENSURE the people of the Veterans Administration receive quality leadership, adequate compensation, decent working conditions, necessary training and education, equal opportunity and earned recognition." This has become the V.A.'s lowest priority and least addressed mission/goal. Yet, the staff that is not provided high quality work conditions seeks employment elsewhere and the veteran receives a lower quality of care because this creates a higher turnover in care providers. Allowing registered nurses and other health care professionals input and control of their working conditions through collective bargaining will help to decrease stress, improve work conditions and increase job satisfaction. Nurses and other professionals training at V.A. facilities will recognize the quality working conditions and will be attracted to the V.A. when they pursue careers.

Gentlemen, it is time to insert into Title 38 language that asserts the original intent of the Title 5 legislation by including in section 4108 the following language:

> While the administrator can prescribe by regulation the hours and conditions of employment, etc., the employees under this title who form recognized bargaining groups under Title 5, Chapter 71 will obtain and retain all rights prescribed under Title 5 chapter 71 including, but not limited to, negotiating with the administrator, or his duly authorized representative conditions of employment as outlined in Title 5 Chapter 71.

Anything less dilutes the original intent of the law.

While we support the language in S-13 we prefer the language given above in paragraph of our statement. AFGE Local 3943 request your assistance by passing legislation to address the bargaining rights problems of the registered nurses and other health care professions in Title 38 soon.

Thank you.

Vera Logan
President AFGE Local 3943

American Society of Hospital Pharmacists
4630 Montgomery Avenue
Bethesda, MD 20814

(301) 657-3000

July 14, 1989

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
U. S. Senate
Washington, D. C. 20510

Re: S. 947-"Veterans Health-Care Personnel Act of 1989"

Dear Mr. Chairman:

The American Society of Hospital Pharmacists (ASHP), the national professional organization representing pharmacists practicing in hospitals and other organized health care settings, is pleased to comment on S. 947, the Veterans Health-Care Personnel Act of 1989, designed to help the Department of Veterans' Affairs (VA) recruit and retain qualified health care personnel. Membership in ASHP exceeds 23,000.

Effective pharmaceutical services are critical to both provision of high quality care and control of the Department's health-care costs. Through such services as review of drug therapy, centralized intravenous fluid admixture and other clinical activities, pharmacists can help optimize drug therapy and prevent adverse drug reactions and interactions. These steps can reduce lengthy hospitalization and prevent costly drug therapy complications leading to rehospitalization.

Pharmaceutical services designed to enhance patient compliance, eliminate duplicative therapies, and avoid the incidence of costly drug interactions will only be possible if the staffing levels for pharmacists are maintained and the high quality of personnel is ensured.

In recent years, VA's difficulty in competing with the private sector for health care personnel, including pharmacists, has become well known. We believe S. 947 can help reduce the twin problems of recruitment and retention of pharmacists but suggest that it contain a recognition of the keen competition facing the Department from both the hospital and non-hospital arenas. Typically, the private sector offers recent pharmacy graduates salaries approximately 50% higher than those at VA with a greater opportunity for advancement.

To help VA better understand these economic forces, we suggest that S. 947 be amended to require the director of each of the Department's health-care facilities to survey both compensation and opportunities for advancement in other establishments where pharmacists are employed.

Specifically, we recommend the following sentence be inserted after the word "positions" on line 21 of page 2 and wherever the language of line 19 appears elsewhere in the bill.

> "In the case of covered positions for pharmacists, the Director shall survey, in addition to non-Department health care facilities within the same labor market area, other establishments where registered pharmacists are employed."

We also suggest inserting the word "pharmacists" on line 25 of page 2 immediately after the first appearance of the word "positions".

We appreciate the opportunity of providing the Committee with our comments on S. 947 and look forward to working with you again in the future. If we can provide you with further information or support, please contact Fern Liang or Tom Bruderle of our Government Affairs Division.

Sincerely,

Joseph A. Oddis

Joseph A. Oddis, Sc.D.
Executive Vice President

cc: The Honorable Frank Murkowski
Ranking Minority Member

ASHP Board of Directors

JAO/mchS947w

CANINE COMPANIONS for INDEPENDENCE, founded in 1975
Exceptional Dogs for Exceptional People

Bonita M. Bergin
Executive Director

Dear Senator Cranston:

I am delighted to offer testimony in support of the proposed S. B. "Veterans Benefits and Health Care Act of 1989," specifically, Sections 211, 213-15, and 222-25. The act would establish and support pilot animal programs for hearing impaired veterans.

As Founder-Director of a national non-profit agency that breeds, trains and pairs dogs with the sighted disabled, I wish to add our unqualified support of the proposed legislation. Canine Companions for Independence (CCI) is a 15-year old organization based in Santa Rosa, California, that has graduated over 400 teams of dogs and disabled individuals, including quadriplegics and hearing impaired.

Our offices are located in five regions: San Diego, California; Columbus, Ohio; Farmingdale, New York; Orlando, Florida; with the national office based in Santa Rosa. Four of our centers are actively training and placing dogs. The fifth, Orlando, is expected to be operational in one year.

CCI breeds and trains four kinds of dogs:

- SERVICE dogs assist individuals who are physically challenged. These dogs turn on and off light switches, push elevator buttons, retrieve dropped items and pull wheelchairs. Typically, SERVICE dogs help people disabled from a spinal cord injury, polio, cerebral palsy, muscular dystrophy, arthritis or a stroke.
- SIGNAL dogs alert individuals who are deaf or hearing impaired to crucial sounds: the ring of a telephone, an alarm clock or a smoke detector, the cry of a baby or the knock on a door. People--especially children--living in a silent world become aware of activities around them as they learn to "see" sounds by following the direction of their SIGNAL dog's antenna-like ears.
- SOCIAL dogs work in institutions and with individuals who are convalescing, autistic or developmentally disabled. The dogs provide the loving, nonjudgmental interaction known as Pet-Facilitated Therapy.
- SPECIALTY dogs are custom-trained to meet the needs of individuals who have multiple disabilities: for instance, a person who is both physically disabled and deaf--a condition which occurs with certain disabilities--or as seen with the effects of aging.

The dogs for the program, purebred Labrador Retrievers, Golden Retrievers and Border Collies, are provided through our breeding program which assures a high quality of animal with desired trainability and temperament characteristics. Volunteer families, or "Puppy Raisers," raise the pups from eight weeks to 18 months, after which the pups are returned to the CCI Regional Training Center for six months of daily training. These dogs learn 89 voice commands that will make them the "arms and legs" or "ears" for the disabled.

Four times a year, students are selected and invited to attend a two week training session called "Boot Camp." These sessions, lasting up to twelve hours per day, teach them skills needed to work with and care for their dogs in the classroom and out in public settings with challenging physical barriers. They are also matched to dogs most suited physically and temperamentally to their needs. After graduation, students are monitored and counseled on the care of their dogs.

CCI has graduated over 400 student/canine teams, usually in classes of 7 to 12 individuals. Our Northwest Regional Training Center has just completed its first graduation in its recently constructed residential training facility.

Students are charged only an application fee of $125. Full costs of $10,000 per dog for breeding, raising, training, and placement are made up with private donations. This is less than the $11,700 to $21,000 estimated cost to raise and train assistance monkeys. No public funds have been received, although we would welcome such a program and think it is overdue.

I would like to close by addressing myself specifically to the proposed legislation concerning SIGNAL dogs.

Preparation for a successful Canine Companion team begins long before the birth of the dog. Through extensive research and breeding, CCI has selected and and developed a stock of Welsh Corgies and Border Collies to assure healthy, intelligent dogs who have an acutely developed sense of hearing. These dogs are further tested at birth for both temperment and physical defects.

Like our SERVICE dogs, our SIGNAL dogs are placed with volunteer puppy raiser families who train and socialize the dogs for 18 months. They are then ready for further testing and professional training.

SIGNAL dog training differs considerably from the SERVICE dog training. SIGNAL dogs are trained to distinguish and respond selectively to different sounds. The dog must evaluate the sound and determine danger response or simply alert the master to the phone or doorbell. Many of our SIGNAL dogs are further trained to respond to commands given in American Sign Language.

During Bootcamp, the student is trained to give the proper commands and form a strong emotional bond of trust and love to evoke the protective instinct of the dog.

All this service is offered willingly by the SIGNAL dog, as is love and companionship. These dogs also act as ice breakers in public, attracting people to interact with the disabled individual--a unique and valuable contribution to his life.

I urge you to consider establishing a pilot program in the Veterans Administration to provide SIGNAL dogs for veterans. I am confident the program will demonstrate the sound basis for later expansion. It will also demonstrate the improved tax savings and quality of life we all seek for our worthy veterans.

Thank you.

Bonita M. Bergin
Executive Director, Founder
Canine Companions for Independence

TESTIMONY
DR. JAMES B. EDWARDS, D.M.D., PRESIDENT
MEDICAL UNIVERSITY OF SOUTH CAROLINA
PRESENTED TO
THE SENATE VETERANS AFFAIRS COMMITTEE
U.S. SENATE
WASHINGTON, D.C.
MAY 18, 1989

Mister Chairman and Members of the Senate Veterans Affairs Committee, thank you very much for the opportunity to present this testimony for the record on the quality of medical care available to America's armed services veterans, and to support S-165. This legislation authorizes the construction of a joint Veterans Administration-Medical University of South Carolina Research Center in Charleston, South Carolina. I wish to thank you members of the Veterans Affairs Committee for your support of Veterans matters and particularly for the support of health care to those who have served this nation. I also wish to publicly thank South Carolina's Senior Senator, Senator Strom Thurmond, for his interest in serving Veterans and for his interest and active support of this important project. This partnership between the Veterans Administration and the State of South Carolina makes sense and can be most beneficial to those we serve.

As President Teddy Roosevelt once said, "A man who is good enough to shed his blood for his country is good enough to be given a square deal afterwards." We at the Medical University of South Carolina (MUSC), the oldest medical school in the South, have long shared this commitment. Over the years, MUSC and the Veterans Administration in Charleston, South Carolina, have worked together to provide the very best possible health care to all eligible veterans.

Today, our shared commitment to serving America's veterans is stronger than ever. However, it is being undermined by the desperate need for larger, more modern research and educational facilities, as well as certain pressures caused by demographic changes in the veterans' population, which I will explain more fully later in my testimony.

My purpose in providing this testimony is twofold. First, to illuminate, in President Bush's words, "the crying need for strong health care for veterans." And second, to describe how the collaborative efforts of the Medical University of South Carolina and the VA Administration at Charleston will help meet this crying need which in the years ahead will grow, not diminish.

The U.S. Veterans Administration is particularly concerned about the "graying of America" -- the rise in the average age of our nation's population -- particularly among veterans. By the year 2000, more than one-third of the veteran population, or about 8 million veterans, will be 65 or older. Even if usage rates were to remain at their current rate of almost 25 percent of veterans over 65, it's estimated that by the turn of the century older veterans will be entering VA hospitals for medical care at a rate of more than 2.2 million per year -- almost twice as many as in 1981.

Providing quality health care to treat age-related disorders and a variety of other diseases, some of which are unique to veterans, is central to the mission of the Veterans Administration. Ambitious research programs studying alcoholism, schizophrenia, spinal cord injury, tissue regeneration, delayed stress, and health problems associated with exposure to Agent Orange are all being undertaken by the Veterans Administration and its affiliated medical centers, hospitals, and research institutes.

Historically, the Veterans Administration has recognized the symbiotic relationship between advancing science through research and providing the finest medical care to millions of veterans. As a result, selfless scientists working in VA labs around the United States have made breakthroughs that improve the quality of life of America's veterans through improved surgical techniques, more effective medicines, and better rehabilitative programs.

After World War II, to ensure the highest quality of care and help upgrade the entire Veterans Administration hospital system, the VA began linking its hospitals with nearby medical schools. Having VA hospitals affiliated with medical schools made it possible for the first time to analyze problems unique to war veterans within the broader scope of the university research laboratory.

It is this tradition, combined with the commitment to search for new ways to improve health care for veterans, which has given birth to the proposal for a partnership between the Medical University of South Carolina and the VA Administration at Charleston to build a joint Biomedical Research Center.

The Biomedical Research Center will be located conveniently to the MUSC Basic Sciences Building and the VA Hospital. It will maximize the strengths of both institutions by combining the basic sciences laboratories of MUSC with the disease-oriented program of the existing VA facilities. And by building one research facility to serve both institutions, money will be saved by avoiding the costly duplication of laboratory equipment, building maintenance, and other related expenses.

Quite simply, the Biomedical Research Center will provide the opportunity for collaborative research, medical care, and education that will benefit veterans -- and other patients served by the Center -- far beyond anything currently available to them. By freeing space in the present VAMC, the Biomedical Research Center will increase by approximately 10 percent the number of critical care beds available for South Carolina and Georgia veterans -- beds that are already badly needed.

The Biomedical Research Center will be comprised of laboratories for VA research in geriatrics, diabetes, heart disease, arthritis, and connective tissue disorders; laboratories for molecular and cellular biology; laboratories for neurosciences, neonatal, prenatal and childhood development programs, and epidemiology; and shared instrumentation and meeting rooms.

By joining in this joint venture of medical research, care, and education, the Medical University of South Carolina and the Veterans Administration at Charleston will make a vast and important contribution to the quality of life of America's veterans -- and our nation as a whole. The Biomedical Research Center will be a cost-effective, innovative, and invaluable facility.

Because of its enormous benefits, Biomedical Research Center enjoys the strong support of the state of South Carolina and key leaders of the South Carolina medical and veterans communities. The state of South Carolina's support is reflected in its commitment to fund one-half of the Biomedical Research Center's total cost of $24 million. This is in addition to the necessary land which is at a premium on the peninsula of Charleston. We are requesting that the remaining $12 million be provided in federal funding -- funding that will be returned to the taxpayer many times over in the form of better, more efficient medical care.

Thank you again for this opportunity to provide written testimony, and your continued efforts on behalf of the health and well-being of America's armed services veterans.

WRITTEN TESTIMONY SUBMITTED BY ERIC K. GROSMAIRE, MS, RRT, WITH REGARD TO THE VETERANS' HEALTH-CARE PERSONNEL ACT OF 1989.

May 8, 1989

Senate Committee on Veteran's Affairs
414 Russell Senate Office Building
Washington, D.C. 20510

To the Honorable Senator Cranston:

The following comments are being submitted as written testimony for a hearing on May 18, 1989, with regard to the "Veterans' Health-Care Personnel Act of 1989."

For many reasons, there has been a decline in the number of people entering the allied health professions. While nursing has been the focus of attention, this scarcity of practitioners also affects other professional groups, including respiratory therapy.

The current bill would mandate a number of benefits for nurses, including these: salaries competitive with other hospitals in that labor market, yearly wage surveys, competitive shift differentials, various scholarship programs and so on to improve recruitment and retention of nurses in the VA system. Other health care professions could be included but only "...upon the recommendation of the Chief Medical Director in each such facility." When salary and benefits are made optional for groups other than nurses, it has been my experience that these benefits are seldom enacted. For example, in the 1988 Veteran's Health Care Benefit Act, the option of Saturday premium pay was made available for nursing and other groups included in Title 38. Nurses received this benefit at many stations; however, respiratory therapy sections receiving this benefit were far fewer in number. I strongly suspect, given the financial constraints of the VA, that these options in the 1989 Act will not be extended beyond nursing.

Respiratory therapy (RT) sections in the VA have also been experiencing recruitment and retention problems. Practitioners either refuse to enter the system or leave the system for many reasons including, 1) low salaries, 2) non-competitive shift and Saturday differentials, 3) lack of guaranteed tuition reimbursement and, 4) extended periods between pay raises for employees in the higher steps. Just as an example, I made an appointment this morning to interview a Certified Respiratory Therapy Technician (CRTT) with slightly less than two year's experience. If we decide to hire this candidate prior to her achieving two years experience, she will be classified as a GS-6. Her current salary is $2500 MORE than the GS-6/10 salary. If we were to hire this candidate after she completed two years of experience, we could bring her on board as a GS-7/10. which would just match her old salary. As a 7/10, this candidate is not eligible for a raise unless this facility receives permission to implement special salary rates. If I were in this candidate's shoes, I doubt I would accept such an offer.

Credentialed respiratory therapy practitioners (Title 38) should be included, by name and not by option, in this Act for the following reasons:

1. Respiratory therapy practitioners are an integral part of the intensive care unit and work alongside nurses performing patient care. If, the VA cannot recruit and/or retain qualified respiratory therapists and technicians, someone will have perform those responsibilities and that will have to be the nurses. The other option is to cut services and/or beds in the units.

2. As respiratory therapy technology becomes more and more complex (e.g., computerization of equipment), it will require employees who have higher levels of education. If the VA wants to have any hope of recruiting and retaining these people, salaries and benefits will have to remain competitive with the private sector. This will require frequent reviews of salary and benefit's packages from competing hospitals, as well as a speedy mechanism for implementing these changes. In addition, the salary survey should also provide a mechanism for reviewing and upgrading the salaries of shift supervisors, chiefs and ass't chiefs of respiratory care sections. The current survey does not have a mechanism for providing this information. Consequently, if special salary rates are approved, the respiratory staff will get a raise, but the supervisors and managers do not.

3. According to a 1986 survey (see attached), there were approximately 724 credentialed respiratory therapy practitioners in the system (RRT=208 and CRTT=516). Therefore, any addition to this Act which would mandate changes in the RT salary and benefit's package should not produce a great deal of extra expenditure, when compared to the numbers of people found in nursing.

4. Finally, quality patient care depends upon recruiting and retaining well educated, highly trained staff. This can only be done with a salary and benefit's package which is competitive with those found in the local private sector hospitals. These hospitals know the value of having a good respiratory therapy department and are making the effort to improve their offerings to recruit the necessary staff. Each time the local hospitals improve, and the VA remains unchanged, it becomes more difficult to attract and retain well qualified people. The current process of requesting special salary rates is slow, bureaucratic, and cumbersome. If respiratory therapy in the VA wants to have any hope of

adequately competing with the private sector, then they must also be included in the 1989 Act, not as an option, but as a mandate.

Thank you for your time and attention to these matters. If you would like additional information or have any questions, please feel free to contact me.

Sincerely,

Eric K. Grosmaire

Eric K. Grosmaire MS, RRT
Ass't Chief, Respiratory Care/PFL
James A. Haley VAMC (111C)
13000 Bruce Downs Blvd.
Tampa, FL 33612

ATTACHMENT 1

Credentialed Respiratory Therapy
Personnel in the VA

In 1984, according to a survey conducted by Circular 10-84-69 (RCS 10-84-10), there were 1,332 respiratory therapy/inhalation therapy personnel employed in the VA. Of these 133 (10%) were registered respiratory therapists (RRT) and 453 (34%) were certified respiratory therapy technicians (CRTT). At that time, 22 stations reported employing no credential therapists at all and 79 had no registered therapists.

Since then, PL 98-160, has been implemented which gave the VA authority to appoint credentialed respiratory therapy personnel under title 38 and to convert those already employed to the title 38 system, (Circular 00-85-9, dated, March 12, 1985).

In August 1986, a survey was done of respiratory therapy personnel using the automated list of DM&S Personnel in Pay Status (6-30-86, RCS 10-00-37) in the following categories RRTs, CRTTs, respiratory therapists and inhalation therapy technicians. The last two categories are uncredentialed. 15 stations appeared to have personnel classified as medical machine technicians in respiratory therapy roles, although these accounted for only 60 FTEE. This would be approximately 4% of the total respiratory therapy staff. 219 RRTs are now employed in the system, an increase of 86 (65%). There are 527 CRTTs, an increase of 74 (16%). RRTs now comprise 15% of all personnel and CRTTs, 37%. Over half (52%) of all employees are credentialed compared to only 44%, two years ago. There has also been an increase in the total number of employees of approximately 8% (from 1,332 to 1,432 FTEE).

The sizes of the units varied from 1-26 FTEE with a mean and median size of 10. Two years ago only 30 units had 15 or more personnel, now 35 do.

Credentialed employees now range in grade from GS5 through 11. A comparison of the grade distribution in 1984 and 1986 follows:

Grade	RRTs in 1984	RRTs in 1986	CRTTs in 1984	CRTTs in 1986
4	0	0	1	0
5	1	0	25	16
6	30	1	205	75
7	31	17	97	396
8	8	117	22	18
9	23	25	19	9
10	9	32	2	1
11	5	17	0	1

Grades were either not reported or not readily available on all employees. However, 80% of those reported in 1984 and 96% of those in the PAID list in 1986 are covered in the above chart. All 29 CRTTs above a grade 7 are in supervisory roles and have been granted a grade waiver by local and VACO Professional Standards Boards.

The provisions of PL 98-160 relating to the employment and pay of credentialed respiratory therapy personnel appear to have been successful in attracting RRTs and CRTTs to VA positions in the 14 months covered by this survey. This trend is expected to continue as vacancies occur, and current employees upgrade their own status and become credentialed.

SUSAN H. MATHER, M. D.
Medical Service (111)
FTS 389-2450

Statement of Mary Joan Willard, Assistant Professor of Rehabilitation Medicine at Boston University School of Medicine, and Director of Helping Hands: Simian Aides for the Disabled, Inc. Given before the Senate Committee on Veterans Affairs concerning S13, a bill to authorize the Administrator of Veterans' Affairs to provide assistive animals to certain veterans.

May 18, 1989

Introduction

I am Mary Joan Willard. I am a behavioral psychologist on the faculty of the Department of Rehabilitation Medicine at Boston University School of Medicine. At the medical school I do research on the training of capuchin monkeys to serve as aides for quadriplegics. I am also Director of Helping Hands: Simian Aides for the Disabled, Inc., a non-profit organization which seeks to implement research results and place trained capuchin with quadriplegics across the country.

Mr. Chairman and Members of the Committee, I want to thank you for the opportunity to present my views concerning S13, introduced by Senator Alan Cranston. This bill will amend Title 38, United States Code, to specifically authorize the Administrator to provide assistive animals to certain quadriplegic veterans.

Although the testimony which follows has been updated, similar information was presented to this committee in June of 1988 when I gave testimony concerning Senator Murkowski's bill, S2207. The most significant development since that hearing has been the completion of an evaluation of the Helping Hands program by the Evaluation Unit of the Veterans Administration Rehabilitation Research and Development Department. Although the official report has not yet been released, I have been told that the evaluation itself was very positive. A complete report can be obtained from Dr. Margaret Giannini's office at the Veterans' Administration.

Background on Quadriplegics

Recent medical progress has permitted the survival of very severely disabled people who, although totally paralyzed, have normal cognitive and communication skills. In many cases, severely disabled individuals also have a normal life expectancy. The most dramatic example is the high level spinal cord injured quadriplegic who is paralyzed, in varying degrees, from the shoulders down. As of 1985, there were at least 110,000 spinal cord injured quadriplegics in the United States. Eighty-two percent of them are male and most are young. Sixty-one percent were between the ages of 16 and 30 at the time of their injury (Spinal Cord Injury: The Facts and Figures, 1986).

To live outside of a chronic care institution, a high level quadriplegic typically requires a minimum of four to six hours a day of human help. The disabled individual usually receives this help from one or more family members who must make drastic changes in their own lives to provide it, and/or from paid personal care attendants (PCA). The relative or PCA assists with tasks such as bathing, dressing, bowel and bladder routines, household tasks, and transfer into and out of a wheelchair.

In addition to these essential tasks, which are usually performed in the morning and again at night, a high level quadriplegic may require help to perform countless small tasks during the course of a day. Putting a book or magazine on a reading stand, placing a cassette into a tape recorder, getting a drink, eating a meal, and retrieving a fallen mouthstick are all tasks that require assistance.

Few quadriplegics have families that can provide assistance throughout the day, and fewer still can afford full-time paid attendants. Many quadriplegics simply do without. These individuals are surviving, but the quality of their lives leaves room for a great deal of improvement.

Feasibility of Monkey Helpers

Specially trained and equipped capuchins can serve as helpers and companion animals for up to 8 hours a day. They are useful for quadriplegics who are left alone on a regular basis or for those who would like to function independently. The first quadriplegic to receive a monkey helper was Robert F., a young man living in a Boston suburb. Because Robert's situation is typical of many experienced by high level quadriplegics, it will be used to illustrate the role that a monkey helper can play in someone's life.

At the age of 18, Robert was paralyzed from the shoulders down as the result of an automobile accident. One year after the accident, Robert began to live independently with the aid of a personal care attendant. Massachusetts, which is relatively generous in the aid it will provide to the disabled, provided Robert with 6 hours a day of personal care attendant time. Robert's aide, who shared his apartment with him, cared for Robert in the morning and again in the evening. During the day the aide held a full-time job and thus Robert remained alone in his apartment approximately 9 hours a day, 5 days a week.

In November of 1979, Robert began to participate in a pilot project to test the feasibility of simian aides. Since then, Hellion, a 6 pound female capuchin monkey has lived with him as a helper and companion. Robert communicates his needs to Hellion by aiming a small harmless laser pointer at the object he wants her to manipulate. The laser is mounted on the chin control mechanism of his wheelchair. Robert points it by gripping a small stick in his teeth. He uses the laser beam plus a verbal command to indicate what Hellion is to do with the object. When Hellion has completed a task, Robert rewards her with both verbal praise and a treat from the reward dispenser mounted on his wheelchair.

One of the most frequent chores performed by Hellion is the repositioning of Robert's chin control arm. Robert must push the arm away from his face with his chin dozens of times each day. Once out of position, Robert can lean forward to relieve sitting pressure, reach food, or manipulate equipment with a mouthstick. Regaining access to the control arm can be tricky. If it is slightly out of reach, Robert is unable to drive his electric wheelchair. Hellion repositions the arm for him several times a day. Robert uses his mouthstick to turn pages of a book, type into a computer, or dial a phone. If the 18 inch, rubber tipped stick is dropped, Hellion can reposition the correct end in Robert's mouth. Should Robert want a drink or a sandwich, Hellion can retrieve these items from a small refrigerator, position them in a feeding tray and open them. Hellion can insert a cassette tape into a tape recorder or place a designated book on a reading stand. Any non-fragile small item can be transferred by Robert's monkey to virtually any location in a room. Robert can, for example, have Hellion fetch a TV remote control to him or throw wastepaper into a trash can. Hellion will follow the laser beam controlled by Robert who indicates both the object he wants her to transfer and its destination. Hellion will come when called, and return to her cage on command, locking the door behind her. Her overall task reliability is 94%.

Since 1981, 14 additional quadriplegics have received monkey helpers as part of an ongoing research project. Each placement functioned as a mini-experiment as new types of living situations, training techniques, and methods of placement are attempted. Although most quadriplegics use the standard repertoire of tasks described above, other behaviors that have been taught include having a monkey reposition a quadriplegic's arm on a wheelchair laptray when spasms result in it falling out of position. Scratching annoying itches with a soft face cloth is a popular task. A quadriplegic indicates the area of his face or neck to be scratched by leaning into the cloth, and the monkey will scrub the general area vigorously until the owner indicates that it is time to stop. Monkeys can position videotapes so that a quadriplegic can guide them into a VCR recorder with a mouthstick, or load a CD into a CD player.

Simple manual tasks required a dozen times a day are performed quite readily by a capuchin. They perform them for a sip of juice dispensed from a wheelchair mounted bottle that is controlled by their owner. They also perform for the praise and affection that they receive. Since 1979 when Hellion was first placed with Robert, he has employed 9 different human attendants. Hellion remains his one and only monkey helper.

Control of Destructive Behavior

Curiosity will lead these monkeys to climb on bookcases and tables, open cabinets, and empty trash cans. They may also get into cleaning supplies or medicine which can be toxic. To keep them from destroying someone's home and protect them from harm, a system was devised to teach them to avoid certain pieces of furniture or areas of the house. White 1-inch circular stickers are pasted on all off-limit objects. Several stickers on the side of a desk, for example, mean the desk and everything on top of the desk cannot be touched.

If a monkey breaks the rule and touches a stickered object, she is given a warning tone from a transmitter mounted on the wheelchair. If the monkey continues to disobey, she is given a tone plus a 0.5 second shock to her tail. The shock level causes no damage, but is just unpleasant enough that it is not worth it to the monkey to break the rule. The 2 1/2 ounce tone/shock unit is held in a leather harness that depending on the monkey, may be worn daily, or as infrequently as once every few months.

Once a monkey is familiar with exactly what is off limits in a quadriplegic's apartment, she can play freely in whichever room her owner may be in. Most monkeys spend 8-14 hours each day out of their cages. They return to their cages to urinate, defecate, sleep or eat. Although the threat of punishment is used to enforce this essential obedience command, it is never used as an "incentive" for the performance of helping behaviors. Positive reinforcement alone is used with tasks. It yields a satisfactory 90% reliability rate.

Monkey Aggression

Even very tame capuchins have been known to attack unfamiliar humans. Within a few months of moving into a home, a monkey will behave toward the household members as if they are part of her troop. The quadriplegic owner generally is at the top of the hierarchy, with relatives and attendants each assigned a rank. Visitors and those at the bottom of the hierarchy can never be totally certain as to when the ordinarily playful, affectionate monkey might view them as a threat, and bite.

To eliminate the possibility that any capuchin aide might harm someone, these monkeys undergo a full mouth teeth extraction when they reach maturity (3-1/2 to 4 years of age). This operation has for many years been commonly performed on monkeys used by organ grinders without affecting the animal's diet (monkey chow is softened). All of the monkeys placed through this project have undergone full mouth teeth extractions without any deleterious effects on their health or subsequent behavior, or any perceptible long-term discomfort.

Choice of Monkey

Cebus monkeys are commonly called capuchins or organ grinder monkeys. The genus name is Cebus. There are four species and 39 subspecies within that genus. Cebus monkeys were selected for this role because of their intelligence, small size, and ability to manipulate objects. The phlegmatic temperament of Cebus apella results in a longer attention span which is a valuable asset in training. Equally important is the quality of the companionship they can provide. Adult Cebus apella will sit quietly in their owner's lap or look out the window for hours at a time. Capuchins will watch TV intermittently. They enjoy manipulating toys such as busy boxes used by 6-18 month old children. Their favorite activity is to groom their disabled owners, which means that they delicately pick through hair or clothes looking for bugs.

Psychological Factors

Although the primary goal of this project is to increase the ability of a quadriplegic to perform the tasks of everyday life, this unusual intervention has had a strong psychological impact on disabled participants.

Most high level quadriplegics lead very restricted lives, often spending weeks at a time within the confines of their homes. An affectionate, responsive and entertaining capuchin can be a very welcome addition to an unstimulating environment. A quadriplegic owner will often refer to his monkey as his "baby." The role these monkeys play in the lives of their quadriplegic owners is often very similar to the role children play in the lives of parents.

Ownership of a monkey also seems to convey a certain status on the recipient. Monkeys outside of zoos are rare. Monkeys who perform chores like small humans and readily play with visitors are even more unusual. Quadriplegics acquiring a monkey aide have reported that overnight they feel as if they became a mini-celebrity in their neighborhood. Ownership of a monkey provides an obvious and interesting topic of conversation. It can minimize the discomfort the able bodied feel when relating to the disabled, and allow for the more natural development of friendships. Considering the circumstances in which many quadriplegics find themselves, the importance of these social factors cannot be overestimated. For psychological reasons as well as financial, it's fortunate that these monkeys have a life expectancy of 30 years.

Helping Hands: Simian Aides for the Disabled. A service organization

By 1982, it was clear that functionally and psychologically, simian aides could make a major contribution to the lives of at least some quadriplegics. Further research was needed to refine the procedures by which they were socialized, trained, and placed, but the basic concept proved to be feasible. A non-profit organization called Helping Hands: Simian Aides for the Disabled, Inc. was established to meet the goal of providing monkey helpers to quadriplegics - much like guide dogs are now offered to the blind.

Sources of Cebus Apella

Helping Hands' breeding colony is located on Discovery Island at Walt Disney World in Florida. This colony is expected to produce the majority of the monkeys that will enter into the foster family program. Other sources of monkeys include donations from private individuals and other breeding facilities. Helping Hands has also become a safe haven for stray monkeys and for those that have been confiscated by various government agencies.

Foster Homes

Trial and error testing has demonstrated that early socialization is essential for the production of affectionate and humanized primates. When baby monkeys are six to eight weeks of age, they are placed with foster families, who volunteer to raise them in their homes for a period of 3 1/2-4 years. Volunteers agree to spend 10 hours a day with their primate babies during the first six months. Foster parents literally carry their primate babies on their arms as they go about their daily business. Older animals require less extensive contact, but a minimum of four hours each day must still be spent interacting with the monkey outside of its cage. There are currently about 85 young monkeys being socialized by volunteers. Over 100 additional families have passed the screening process and are awaiting the opportunity to foster animals as they become available. A part time foster care director screens, coordinates and monitors the placements.

Training

Socialized monkeys are sent to a training school in Boston. They are trained 5-6 times a week for 45 minute sessions. A standard repertoire of obedience and helping tasks takes approximately 6 months to teach.

Training is performed by college work-study students from Boston University. These are undergraduates who can make a 2-4 year commitment to the program. They work from 10-20 hours each week as part of their financial aid package and train under the supervision of a professional. Not only is student labor relatively inexpensive, but students are developmentally well suited to the job demands. They have energy, dedication, and patience, and are often thrilled with the opportunity to train primates.

Evaluation of Quadriplegic Candidates

Once the candidate has completed an application, they and their primary care attendant are interviewed at length over the phone. A home visit is scheduled for those who seem most suitable. A videotape is made of the interview with the disabled person, his/her attendant(s), and other household members. Details of the quadriplegic's environment, equipment, and physical abilities are also recorded and reviewed back at the laboratory, to help custom train a monkey to meet specific needs. Individuals are selected to receive a monkey based on their needs and characteristics, as well as the needs, abilities, and personalities of the specific monkeys in training at that particular time. A character reference check is performed for all candidates designated as likely to receive a monkey. These individuals are not only receiving a special form of assistance, they are accepting responsibility for the welfare of another living creature.

Placement

During the actual placement, a trainer travels to the home of the quadriplegic and works with that individual, his/her family, and the monkey for 4-7 days. A support person is hired to come in one hour a day for the next 6-8 weeks, to help the monkey develop a routine with the disabled person in the new home environment. By the end of that period, the monkey's tasks are usually transferred and under the control of the new owner. A complete social adjustment on the part of the monkey and the household members may take up to six months depending upon the personality of the monkey and the number of people in the household to which the monkey must become accustomed. Each placement receives a follow-up home visit 3-6 months post placement. Ownership of the monkey is transferred once the placement director has evaluated the daily routine, problem solving skills and total adjustment of both monkey and household members to one another.

Who is Appropriate for a Monkey Helper

Approximately 74% of quadriplegics or 66,600 disabled individuals in this country are physically appropriate for a monkey helper. Of those who are physically appropriate, it is estimated that 10-25% or 6,600 to 16,600 individuals fit all of the selection criteria. These criteria are listed in Appendix A of this report. Of the 2,300 service connected veterans, between 170 and 425 can be expected to be appropriate. A more exact estimate will be available once a market survey of this group has been completed.

Funding History

Research support to explore the feasibility of monkey helpers came initially from the Paralyzed Veterans of America, then the Natural Science Foundation. For the past 6 years it has been provided by the Veterans' Administration Department of Rehabilitation Research and Development.

Private Foundations, most notably the Dodge Foundation and the Educational Foundation of America have also provided support.

The Veterans Administration research grant is administered by the Boston University School of Medicine. M.J. Willard, a behavioral psychologist on the faculty of the Department of Rehabilitation Medicine is the principal investigator on that grant. Dr. Willard is also Director of Helping Hands: Simian Aides for the Disabled, Inc., the service-oriented component of the project. Negotiations are underway to formalize the affiliation between Helping Hands and Boston University. By the summer of 1989 it is expected that resources from both organizations will be used in a service-oriented program that will place monkeys with quadriplegics across the country. It will function similarly to a guide dog program.

Cost Effectiveness

Based on preliminary cost assessments for the placement of 50 animals per year, the cost per placement is 15,700. With an average 20 year working career for each placement, the annualized costs are $785.

If the placement results in the reduction of just one hour per day of attendant time for the average quadriplegic, the program will yield an annual savings of $3,777 for each placement.

Cost to Quadriplegic Recipient

There are nine guide dog schools in this country. They have been so successful in raising funds that any appropriate blind candidate in the United States can receive a guide dog for a token fee of $150. The actual cost of providing the dog is around $21,000 and is covered by private contributions. Like the blind, quadriplegics are rarely in a position to afford the costs of an assistive animal. Support via third party payments, corporation and foundation sponsorship and private contributors will also be sought to offset the placement expenses. Ideally, appropriate quadriplegic candidates will be charged only a nominal sum for a monkey helper.

Cost of a Pilot Program for Service Connected Veterans

Total cost spread over a 3 or 4 year period would be $651,000. A budget is presented in Appendix B.

Other Programs

Although Helping Hands is currently the only service organization in the United States to train and place simian aides, rehabilitation centers in Israel, Belgium, and Canada have begun their own programs with assistance from Helping Hands. This project has the potential not only to help American quadriplegics, but to serve as a model for similar efforts in other parts of the world.

S13

Eleven years of effort and over a million dollars have gone into research on the feasibility of monkey helpers. S13 will enable certain quadriplegic veterans to reap the benefit of that investment. I want to take this opportunity to thank Senator Cranston for his recognition of the merits of this program through the introduction of S13. His efforts on behalf of veterans and the nations disabled individuals in general are greatly appreciated.

Finally, I would like to thank the Paralyzed Veterans of America which first took a chance on this novel research concept in 1979. Their initial financial support and continuing advice and encouragement have made the development of the Helping Hands monkey possible.

Appendix A: Selection Criteria for Monkey Aide Recipients

1. **At least one year post-injury**
   A quadriplegic individual should have sufficient time for his/her life to stabilize after an injury.

2. **A reliable attendant situation**
   Since the attendant will be the primary caregiver to the monkey, it is critically important that the attendant also be involved in the decision to receive a monkey.

3. **Majority of time spent at home**
   A monkey is trained to work in the home environment and it is unfair to leave the monkey alone on a regular basis. As such, individuals who go to school or work full-time outside of the home are not ideally suited to having a monkey aide.

4. **Sufficient motor ability to control an electric wheelchair**
   In order to perform tasks with a monkey aide, an individual must be capable of independent wheelchair mobility to move about the home environment. The same motor ability used to activate a puff-sip, hand, or chin control unit will be utilized to control monkey communication equipment.

5. **Functioning electric wheelchair**
   Much of the equipment used to communicate with a monkey is attached to a wheelchair. For this reason, the wheelchair which will be used on a daily basis must be fully function functioning before an individual can be selected to receive a monkey aide.

6. **A need/desire for independence**
   If at any time a monkey becomes merely a "pet" for the quadriplegic owner, the monkey must be returned to Helping Hands. There are too many people who wish to become more independent that are waiting for monkeys to help them realize their potentials.

7. **Unimpaired cognitive function**
   Individuals who receive monkeys must have good decision making skills, especially in situations when monkeys will occasionally "test the rules." The quadriplegics themselves must also be able to coordinate and monitor the daily care and health of their monkeys.

8. **Adequate verbal communication**
   Individuals must be able to give clear, consistent commands to their monkeys. This increases a monkey's

ability to distinguish one command from another.

9. **No small children in the household**
   Monkeys require a stable, uncluttered home environment in order to perform their tasks accurately and reliably. Young children make it difficult to maintain the structure needed by the monkeys. In addition, young children are capable of doing many of the tasks a monkey can do, and more.

10. **Enthusiasm**
    This comes in many forms... desire to become more independent; willingness to adapt one's home environment to accommodate a monkey; willingness to drill with the monkey in her tasks on a daily basis during the adjustment period after placement, etc.

Appendix B: VA Pilot Program - Capuchin Monkeys as Aides to Quadriplegics

Budget

1990

Production of four videotapes and a placement manual*	122,000
Placement of six monkey helpers with service connected quadriplegic veterans**	186,000
Total	308,000

1991

Placement of seven monkey helpers with service connected veterans	196,000

1992

Placement of seven monkey helpers with service connected veterans	147,000

* Production of the four videotapes and a placement manual is a one time expense that will provide staff with the tools needed to evaluate candidates and make placements both more efficiently and cost effectively.

** The cost per placement is $31,000 during the first year of operation but drops to $21,000 by the third year of the program. Decreased costs are a function of learning effects and the fact that fixed costs will be distributed across a larger number of placements as the overall program grows.

Metropolitan Life Insurance Company
1615 L Street, N.W., Suite 1210, Washington, DC 20036

Metropolitan Life
AND AFFILIATED COMPANIES

Vincent P. Reusing
Senior Vice President

July 11, 1989

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
414 Russell Senate Office Building
Washington, D.C. 20510

Re: S. 573

Dear Chairman Cranston

Metropolitan Life has been a major health insurer for many years. We currently provide insurance coverage to over 40 million Americans. We serve over 9,000 employers including 48 of the Fortune 100 firms. As such, we are diligent in our concern over escalating health care costs, and we would respectfully like to offer our views concerning S. 573.

The Federal government has long played an important role in providing health coverage to large segments of our nation's population through a variety of programs. Those programs such as Medicare, Medicaid, military and veterans play an integral part in assuring the target populations served that they will have adequate health care services when the need arises. This is especially true for our country's military veterans with service connected disabilities. The veterans health care system is uniquely suited to address their special needs.

S. 573 would require veterans with service connected disabilities being treated for non-service connected disabilities to use their private sector health coverage. While it is important for Congress and the Administration to search for ways to curb the national budget, each proposal should be carefully considered to avoid inadvertently causing other problems.

We believe S. 573 is one such instance where the potential for cost savings is far outweighed by the direct problems which would be created were it to be implemented.

Firstly, any costs associated with the provision of health care to veterans with service connected disabilities would be borne by private sector individuals already facing ever increasing health insurance costs. Rather than addressing real systemic cost savings, S. 573 would merely shift those costs to someone else. We believe a more effective approach to cost savings is to improve the cost efficiency of the VA health care system itself.

At the same time, a similar cost cutting approach for Medicaid over the years has, in our view, contributed to the crisis surrounding the 37 million individuals currently without access to basic health care services. This fundamental withdrawal of financial support for this program is not the best model for the Federal government to follow for the veterans health care system. S. 573 appears to head in this direction and we hope that you will reconsider this approach. For these reasons we oppose S. 573.

Sincerely

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

TESTIMONY

May 18, 1989

To The
Committee on Veterans Affairs

UNITED STATES SENATE

Support for Legislation to Extend the Authority for the Program of Construction Grants to States for State Home Facilities and Funding.

S.13 and S.748

Submitted by:
Jack J. Dack, Chairman
National Association of
State Veterans Homes
Legislative Committee
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

Mr. Chairman and Members of the Committee:

The National Association of State Veterans Homes appreciates the opportunity to express its views pertinent to those sections in the following Bills applicable to the State Veterans Home Program:

A. S.13 - To amend title 38, United States Code, to increase the rates of disability compensation and dependency and indemnity compensation for veterans and survivors, to increase the allowances paid to disabled veterans pursuing rehabilitation programs and to the dependents and survivors of certain disabled veterans pursuing programs of education, and to improve various programs of benefits and health-care services for veterans; and for other purposes.

B. S.748 - To amend title 38, United States Code, and other provisions of law, to extend the authority of the Department of Veterans' Affairs (DVA) to continue the State Home grant and respite care programs and to revise DVA authority to furnish outpatient dental care.

We feel our involvement to be extremely important with the increasing demands being made upon our federal government for funding in taking care of our veterans, particularly those increasing numbers of elderly veterans who are reaching that time in life when the long-term health care delivery system within the Department of Veterans Affairs will be stretched beyond capacity to partially meet this demand.

The State Veterans Home Program has grown from eleven Homes in eleven states in 1888 to presently 58 DVA recognized Homes in 36 states. Nursing home care is provided in 50 Homes, domiciliary care in 42 Homes and hospital care in 7 Homes. These Homes presently have over 18,000 DVA approved beds and in FY88, provided more than 4.8 million days of care (domiciliary 1,464,852; nursing home 3,162,235; hospital 178,933).

The program of assistance to states for construction, remodeling and renovation of State Home facilities began on August 19, 1964, with the enactment of Public Law 88-450, which authorized annual appropriations of $5 million for making grants to State Homes by the Department of Veterans Affairs. These grants were limited to no more than 50 percent of the cost of constructing new nursing care facilities, expanding or remodeling buildings for use as nursing care facilities and initially equipping such facilities. Not more than 10 percent of the funds appropriated for any fiscal year could be used to assist in construction of nursing home care facilities in any one state.

Since inception of the Construction Grant Program over 24 years ago, Public Laws have continually extended the program through 1989, with significant noted changes in the process for States applying for and receiving grants to assist in the acquisition or construction of state nursing care and domiciliary facilities and in remodeling, modification or alteration of existing buildings for furnishing domiciliary, nursing home or hospital care for veterans in State Homes.

Over the years, increased appropriations have been provided as matching funds for states; construction of new facilities; adding new State Homes and/or remodeling or renovating existing facilities. It is noted that this annual funding has increased from $5,000,000 in 1964 to the present $42,000,000. A historic review of the program indicates a total of $307,082,000 has been appropriated through September 1988. Of this amount, $293,585,000 had been obligated as of September 30, 1988. These obligations were for 212 projects with a total estimated cost of $478,690,000. Overall DVA participation: 61.3% of the estimated cost of projects. There were 76 projects with beds and 136 without beds. Note Attachment A.

In addition to the present number of States with State Veterans Homes, other construction activity is noted. Two new States (Florida and Alabama) are in the process of building State Homes. Four new States (Tennessee, Virginia, Kentucky and Puerto Rico) are awaiting grant awards. States with Homes (Maine, Missouri and New York) are constructing additional Homes to assist in providing long-term health care services for veterans in their respective States. Other States have plans for additional Homes. (Illinois, Pennsylvania, Minnesota and Colorado)

The National Association of State Veterans Homes supports the passage of legislation to extend the program in S.13 and S.748 and to "authorize the appropriation at $42,000,000 for fiscal year ending September 30, 1990, and such sums as may be necessary for each of the four succeeding fiscal years in S.748. Such legislation is vital to the combined state and federal efforts focused on meeting the increasing needs of the nation's aging veteran population. While the total veteran population will get smaller from the present 27.2 million to 24.3 million in the year 2000, it will become older. The group of veterans over 65 years of age, which now numbers close to 6.7 million, will grow to about 9 million. Veterans 65 and over will account for about 37% of the total veteran population. This proportion will rise steadily over the next two decades before peaking at 44.5% by the year 2020.*

The shift within the provider mix in 1986 for DVA sponsored programs in long-term care for veterans to a 30 percent state-supported census will require additional State Veterans Home beds. (State 20-30%, DVA 30-40% and Community Contract 40%) These beds probably cannot be attained without continued support for the necessary appropriations for Grants for Construction of State Extended Care Facilities. Note the current backlog depicted in Attachment B.

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* A CBO study, Veterans Administration Health Care Planning for Future Years. Congress of the United States, Congressional Budget Office 1984, Page 64.

We in the Association are pleased with the recommended $42.0 million request in the Department of Veterans Affairs Fiscal Year 1990 Medical Care Budget for Grants for Construction of State Extended Care Facilities and the reference in S.748 for same as well as "such sums as may be necessary for each of the four succeeding fiscal years." This funding will assist in reducing the backlog of pending construction applications. Based upon the latest priority list subject to change on August 15, 1989, the FY90 appropriation request of $42 million is projected to fund five projects producing 640 nursing home beds and 326 domiciliary beds.

While the Congress of the United States has been most generous in providing for its veterans, and the Department of Veterans Affairs has done an outstanding job within the confines of budgeting limitations in taking care of our veterans, the resources to do so are becoming more limited. We must continue to work closer together, share ideas, stretch and share resources and assist one another if we are going to fulfill our mutual obligation. The nation's commitment to take care of its veterans must be met.

Thank you.

Jack J Dack

Jack J. Dack, Chairman
National Association of
State Veterans Homes
Legislative Committee
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

Attachment A

A total of $307,082,000 has been appropriated from 1966 through September 30, 1988. Of this amount, $293,585,000 had been obligated as of September 30, 1988. These obligations were for 212 projects with a total estimated cost of $478,690,000.

[dollars in thousands]

Location	Projects		Number of New Beds	Total Estimated Cost	Actual VA Commitments/ Obligations
	With Beds	W/O Beds			
Alexander City, Al	1	...	150	$7,629	$4,959
Anderson, SC	1	...	220	12,459	8,098
Ardmore, OK	1	1	100	2,295	1,492
Augusta, GA	1	...	192	1,956	978
Augusta, ME	1	...	120	4,472	2,907
Barboursville, WV	2	...	201	4,060	2,508
Bennington, VT	4	2	185	11,736	6,883
Biddeford, ME	1	...	120	7,500	4,875
Boise, ID	1	...	90	5,246	3,333
Bristol, RI	1	1	315	7,289	4,632
Buffalo, WY	1	1	60	3,191	1,967
Cape Girardeau, MO	1	...	150	8,364	5,436
Charlotte Hall, MD	2	...	252	14,681	9,176
Chelsea, MA	...	17	...	5,404	2,920
Claremont, OK	1	...	250	15,416	9,712
Clinton, OK	2	2	86	2,278	1,403
Columbia Falls, MT	1	...	40	449	220
Columbia, SC	1	...	115	1,982	687
Erie, PA	1	3	75	5,013	2,349
Florence, CO	1	...	120	1,331	848
Ft. Dodge, KS	1	...	88	830	415
Grand Island, NE	2	1	200	3,299	1,333
Grand Rapids, MI	2	...	762	21,754	12,844
Hastings, MN	...	1	...	2,828	1,839
Hollidaysburg, PA	2	3	412	13,543	8,122
Holyoke, MA	1	9	155	3,959	2,046
Homelake, CO	...	5	...	924	598
Hot Springs, SD	...	3	...	217	141
Jackson, LA	1	...	235	8,675	5,000
Jackson, MS	1	...	150	6,198	4,028
King, WI	3	6	445	14,984	8,352
Lafayette, IN	2	...	250	12,532	6,126
Lake City, FL	1	...	150	6,739	4,380
Lisbon, ND	...	2	...	1,781	1,158
Little Rock, AR	2	...	266	2,182	1,418
Manteno, IL	1	...	300	18,094	11,761
Marquette, MI	1	...	194	4,289	2,788
Marshalltown, IA	3	16	620	26,611	16,840
Menlo Park, NJ	2	2	200	5,187	2,696
Mexico, MO	1	...	150	6,336	4,105
Milledgeville, GA	2	1	282	12,284	6,808
Minneapolis, MN	1	4	250	9,513	6,178
Norman, OK	1	1	50	492	246
Orting, WA	1	10	40	4,382	2,805
Paramus, NJ	2	...	354	28,677	18,251
Quincy, IL	1	5	200	4,851	2,716
Retsil, WA	1	7	78	5,236	3,383
Rifle, CO	1	...	100	3,571	2,321
Rocky Hill, CT	...	8	...	2,896	1,667
St. James, MO	1	1	60	1,569	848
Sandusky, OH	1	1	300	21,175	13,975
Scotts Bluff, NE	1	1	50	2,693	1,751
Spring City, PA	2	...	150	1,501	976
Stony Brook, NY	1	...	350	25,400	16,510
Sulfur, OK	...	1	...	107	69
Talihina, OK	1	...	51	3,033	1,971
Tilton, NH	2	...	100	2,516	1,485
Truth or Consequences, NM	1	...	186	5,400	3,476
Vineland, NJ	3	2	300	15,446	8,034
Yountville, CA	1	18	56	44,235	28,742
GRAND TOTALS	76	136	10,375	$478,690	$293,585

Department of Veterans Affairs
Budget in Brief
Fiscal Year 1990

Office of Budget and Finance (Controller)
Washington, D.C. 20420

January 1989

Attachment B

Eligible Preapplications and Applications in Order of Receipt for Grants for Construction of State Extended Care Facilities

(Pending approval - dollars in thousands)
04/30/89

Assurance of Adequate State Funds	No.	FAI No.	State (locality)	Project	Estimated Grant Reques
	1	24-003	MD (Charlotte Hall)	(3rd Phase - 126 Dom/NH Beds)	3,047
	2	24-004	MD (Charlotte Hall)	(4th Phase - 126 Dom/NH Beds)	5,298
	3	06-017B	CA (Yountville)	Rem. Nursing Home 1-3 B	2,482
	4	06-020	CA (Yountville)	Rem. Sec. H Dom	1,369
	5	06-021	CA (Yountville)	Rem. Sec. J Dom	933
	6	06-022	CA (Yountville)	Rem. Sec. K Dom	854
	7	06-023	CA (Yountville)	Rem. Sec. L Dom	812
	8	06-024	CA (Yountville)	Rem. NHC Wings 1-3C-D	3,120
Received	9	42-008	PA (Hollidaysburg)	Renovation-Sommer-148 NH Beds	6,649
	10	29-004	MO (St. James)	Replace NHC Unit (+50 beds)	2,420
	11	06-026	CA (Yountville)	Remodel Annex I NHC	2,441
	12	06-027	CA (Yountville)	Remodel Annex II NHC	2,441
	13	06-032	CA (Yountville)	Renovate Hospital Food Service	46
	14	06-029	CA (Yountville)	Renovations-Storage Areas	195
	15	06-035	CA (Yountville)	Renovations-Admin. Building	325
Received	16	39-010	OH (Sandusky)	New 300 Bed NHC/Dom	13,301
	17	29-006	MO (NW)	New 150 Bed NHC	7,800
Received	18	42-010C	PA (Pennhurst)	Renovations for 180 NHC Beds	3,621
	19	55-011	WI (King)	Renovate NHC Unit	3,187
	20	16-003	ID (Pocatello)	New 22 Dom/60 NHC	2,971
	21	19-026	IA (Clarinda)	Remodel for 68 NHC	2,647
	22	19-027	IA (Marshalltown)	Dietary Facility	2,491
	23	40-012	OK (Clinton)	Dining/Kitchen Facility	1,034
	24	42-012	PA (Pennhurst)	Dietary Facility	2,373
	25	29-007	MO (St. Louis)	New 200 Bed NHC	7,800
	26	47-001	TN (Knoxville)	New 150 Bed NHC	5,045
	27	17-011	IL (LaSalle)	New 120 Bed NHC	4,680
	28	08-008	CO (Walsenburg)	New 120 Bed NHC	2,789
Received	29	26-005	MI (Marquette)	Add 20 NHC/30 Dom/NHC	2,080
	30	36-003	NY (Oxford)	New Wing (PT/OT) Dom/NHC	1,217
Received	31	08-009	CO (Florence)	Dining Facility (NHC)	50
	32	51-001	VA (Roanoke)	New State Home 148 NHC/76 Dom	10,400
	33	16-004	ID (Northern)	New Home 60 NHC/10 Dom	2,979
Received	34	33-003	NH (Tilton)	New 50 NHC Wing	3,202
	35	17-012	IL (Quincy)	Renov. Kitchen	285
Received	36	21-001	KY (Lexington)	New Home 240 NHC/60 Dom	9,670
	37	72-001	PR (Juana Diaz)	New Home 250 Dom	7,203
Received	38	27-007	MN (Silver Bay)	New Home 89 NHC	1,294
Received	39	27-008	MN (Minneapolis)	Food Service & Warehouse	1,073

Assurance of Adequate State Funds	No.	FAI No.	State (locality)	Project	Estimated Grant Reques
	40	42-014	PA (Scranton)	New Home 270 NHC/30 Dom	15,616
	41	39-015	OH (Sandusky)	New 200 NHC/Dom	8,281
	42	47-002	TN (Murfreesboro)	New 120 NHC	4,420
	43	17-013	IL (Quincy)	Convert Dom to 85 NHC	1,625
Received	44	42-015	PA (Erie)	New Heating System	1,229
Received	45	08-010	CO (Homelake)	Add 60 NHC Beds	1,146
	46	12-002	FL (Pending)	120 NHC	6,461
	47	06-036	CA (Yountville)	Sprinkler Dom E	121
	48	38-003	ND (Lisbon)	Convent Dom to 38 NHC & renov.	2,170
	49	25-032	MA (Holyoke)	Handicap Access (NHC)	147
	50	34-014	NJ (Vineland)	Laundry, Warehouse (NHC)	1,168
	51	06-013	CA (Yountville)	Grant Increase Dom, Sec.B	161
					174,169

Summary (as of April 30, 1989)	
Funds Available from FY 88	$10,894
Funds Available from FY 89	$42,000
	$52,894

Applications eligible for which funds are not available $121,275

Remarks:

1. KY 21-001 Estimate increased to $9,670 from $8,743.
2. MN 27-009 Grant Awarded $715,000.
3. ID 16-003 Estimate decreased from 2,979 to 2,971.
4. MN 27-008 Estimate increased to 1,073 from 975.

State Home Construction Grant Program (182C)
Geriatrics & Grants
Management Service
Department of Veterans Affairs
Washington, D.C.

DAV Responses to Questions
from Senator Alan Cranston, Chairman
Senate Veterans Affairs Committee
In Follow-up to the
May 18, 1989
Health Care Hearing

Question

I want to thank you for your thoughtful and very supportive testimony. I noticed, though, that there is no mention of Section 213 of S. 13, which deals with VA's authority to provide grants for state veterans homes. Do you have anything to add on this topic?

Answer

Section 213 proposes appropriate amendment to Section 5033(a), Title 38, USC, extending, for three years, until September 30, 1992, the VA's authority to provide grants for the construction, acquisition, expansion, remodeling and alteration of state veterans homes for the purpose of furnishing domiciliary or nursing home care to veterans. Without question, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system. Recognizing the significant and important role of state veterans homes -- in terms of providing medical care to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program -- we believe it is indeed wise to continue funding this program that ultimately produces savings to the government in terms of both construction and health care costs. Therefore, we are supportive of extending this program.

Question

On procreative services, VA has raised questions on page 6 of its testimony relating to the number of times each couple should be provided services, whether services should be extended to pre- and postnatal services and the delivery itself, and whether services should be provided to couples who have a high likelihood of producing a retarded or disabled child? Could you please review and comment on these VA concerns?

Answer

The DAV has no official position relating to this measure. However, as we have previously testified, our interpretation of this measure is that services would be provided to assist to "achieve pregnancy" (emphasis added) in a veteran or a veteran's spouse where such services are necessary to overcome a service-connected disability impairing the veteran's procreative ability. The DAV does not envision, nor favor, the VA to be required to provide prenatal or postnatal care or any other care associated with any successfully achieved pregnancy. We view the VA's role -- and the intent of Section 211 -- as no more than assisting to achieve pregnancy. This issue engenders significant disagreement and lack of consensus concerning moral, ethical and medical issues. Some of these may never receive consensual agreement. The remaining concerns you mention call into question the issue of medical judgement that we are not necessarily equipped to conclusively answer. Suffice it to say, we are hopeful and would anticipate that no medical procedure would be performed by the VA that had the probability or possibility of producing adverse or untoward complications or results.

S. 1004

The DAV has no official position nor do we have any objection to favorable consideration of Section 2 which would amend Section 620(a)(2) to provide that in Alaska and Hawaii the per diem cost to the VA for furnishing community nursing home care will not exceed 50% of the cost of care to the VA if purchased in a community general hospital in those states.

Section 3 proposes appropriate amendment to Section 628(a)(2), Title 38, USC, to clarify the VA's authority to pay for emergency medical services for veterans participating in a vocational rehabilitation program under Chapter 31, Title 38, USC, when needed medical services are not feasibly available through VA or other government facilities.

Because certain veterans enrolled in the Vocational Rehabilitation Program are not now eligible for coverage of emergency medical care and in order to ensure consistency, we do not necessarily object to this section.

However, we believe there exists a category of veterans who are equally deserving to be considered for reimbursement by the VA of certain expenses incurred in the provision of emergency medical care.

Specifically, we refer to former prisoners-of-war (POWs).

Former POWs have statutory entitlement to inpatient hospital care at VA medical facilities for any disability for which treatment is required (Section 610(a)(1)(F)). Also, medical services are authorized to be provided to POWs on an ambulatory or outpatient basis, as needed, at VA medical facilities (Section 612(a)(3)(A)).

We believe the current statutory scheme providing POWs health care services at VA medical facilities is in keeping with this Committee's and Congress's recognition of the extreme hardships endured by this small, albeit distinguished, category of veterans.

In our view, further amendment to Section 628(a)(2) deserves careful consideration by the Committee to include POWs in the list of veterans who may be considered for entitlement to reimbursement from the VA for the cost of medical care received when an emergent situation arises. (Such action would satisfy DAV Resolution No. 365.)

Section 4 proposes to amend Section 4107(b)(2), Title 38, USC, regarding grades and pay scales for a physician or dentist position in VA Central Office comparable to the position of Director of a Department, medical center, domiciliary, or independent outpatient clinic. Although we have no official position, if enactment of this provision would enhance recruitment and retention of qualified health care professionals in management positions, we would be supportive of this measure.

Section 5 proposes to amend Section 4144(a)(3), Title 38, USC, to authorize the appointment of graduate physical therapists, graduate practical/vocational nurses, graduate occupational therapists, and graduate pharmacists under Title 38, USC, longer than one year for these awaiting licensure of certification. We are supportive of efforts to enhance the recruitment and retention of health care personnel within the VA and, therefore, are supportive of this measure.

Section 6 proposes to amend Section 4205, Title 38, USC, clarifying that monies in the Veterans Canteen Service Revolving Fund may be invested in Department of Treasury securities. DAV has no objection to this proposal.

Section 8 proposes extending for three years -- September 30, 1992 -- VA's authority to provide community based care for homeless chronically ill veterans. DAV is supportive of this measure.

NAGE SEIU
NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES
AFFILIATED WITH SERVICE EMPLOYEES INTERNATIONAL UNION, AFL/CIO
1313 "L" STREET, N.W., WASHINGTON, D.C. 20005
202/371-6644

June 2, 1989

Honorable Alan Cranston
Chairman Senate Committee on Veterans Affairs
414 Russell Office Building
Washington, DC 20510

Dear Mr. Chairman:

Attached please find NAGE's answers to questions submitted by the committee in follow up to the May 18th hearing.

I have also received a letter from our local president at Coatesville VA regarding the staffing problems at that facility - As you are aware the committee asked several questions of the VA witnesses with respect to this situation: We ask that the additional material be included in the record.

Thank you for your continued support of VA employees.

Sincerely,
Ed Murphy
Edward Murphy
Legislative Counsel

1. Currently, 128 VA facilities have implemented special rates for RNs, 127 facilities have implemented special rates for pharmacists, 94 facilities have implemented special rates for physical therapists, and 75 facilities have implemented special rates for LPNs. Although the rates for identical positions may be the same at some facilities, many facilities have salary rates peculiar to the wages of comparable professionals employed in comparable settings within the community. Are any of you aware of any instances where low morale has occurred as a result of these differing pay rates?

2. On page 1 of your testimony you state that your organization represents approximately 15,000 VA employees in 17 medical centers. Broken down separately by profession, please tell us how many registered nurses and other title 38 employees NAGE represents and at which medical centers they are employed.

3. On page 7 of your testimony you state that there are a variety of technical issues involved in making pay surveys and you question whether VA currently has the capability to do such surveys on a broad scale.

   A. To what technical issues are you referring?

   B. How do you envision the S. 947 competitive-pay surveys differing from the surveys currently done for purposes of implementing a special rate?

1. There are many inequities in the current pay system which needs to be addressed. Some hospital administrators have hired employees at above the minimum of the grade, and then failed to increase the salaries of those experienced employees on staff performing the same duties. This created an inequitable and counterproductive situation where senior employees with years of experience were paid less than new hired employees with substantially less experience which exacerbated exisiting morale and retention problems.

Of NAGE locals the union at Newington, Connecticut experienced perhaps the greatest problems of this nature. Difficulty in filling techinician and other vacancies lead management to provide special pay for new hires only. Some senior employees were so angered that they quit while others filed grievances and other related labor appeals.

2. Our organization does not maintain data on our membership based on occupational titles. We are however able to provide you with at least some information on those locations where we have a separate professional unit. These locations are:

Coatesville, PA - Physicians - 30
Grand Junction, CO - RN - 50
276 GS Professionals
Manchester, NH - RN - 137
48 GS Professionals
Brockton, RN - 208
Bedford, MA RN - 240
103 GS Professionals

3. Currently the GS pay surveys are conducted for the federal section by the Bureau of Labor Statistics. The BLS has great credebility with both labor and management based on years of effective work. In fact many firms are quite reluctant to provide wage data and do so only because of BLS excellent reputation in handling this confidential material. We are not convinced the VA enjoys the same reputation in pay and benefits survey committees.

There are a number of technical determinations which BLS's experience and technical expertise qualify them to make including universe, size of firms what constitutes a job match, weight given to data, how to weigh benefits etc. We do not see evidence that suggests local VA Hospitals are experienced in conducting such in depth surveys.

B. The S-947 competitive pay survey would in our view require a detailed job by job comparison of like employees for both pay and benefits. There would be a number of sensitive decisions to be made as to universe, matches, weight, etc. We view this survey as much more detailed and complete than that currently conducted in implementing special rates.

NAGE SEIU

NATIONAL ASSOCIATION OF GOVERNMENT EMPLOYEES

AFFILIATED WITH SERVICE EMPLOYEES INTERNATIONAL UNION, AFL/CIO

LOCAL R3-35
V.A. MEDICAL CENTER
BOX 155
COATESVILLE, PENNSYLVANIA 19320

May 23, 1989

MAY 24 1989

Ed Murphy, NAGE Attorney
2nd Floor
1313 "L" Street, N.W.
Washington, D.C. 20005

I have received a number of complaints over the last two years leading up to this year about shortages of permanent Nursing Assistants, LPN's, and RN's at the Coatesville VA Medical Center. Also, the fact that Nursing Service employees are required on a daily basis to work mandatory overtime. This overtime is required due to employees calling off on sick leave and scheduled annual leave. This mandatory overtime has lead to employees becoming stressful and burned out, as well as employee injuries have increased in Nursing Service. Employees are also having to bring children on station when mandatory overtime is required due to lack of babysitting facilities or babysitters.

There have been many incidents when one Nursing Assistant was left on a locked unit with 20 to 30 psychiatric patients. This is very dangerous to patients and employees. There should always be two or more nursing employees on a locked unit. The head nurses and charges nurses aren't always able to give the daily 24-hour report because of these shortages.

I have met with and discussed these problems with R. C. Meiler, Medical Center Director, James Nocks, M.D., Chief of Staff, J. Pomorski, Chief, Personnel Service, and Marnee McLean, RN, Chief Nurse, on many occasions. It is apparent they have tried everything to resolve these issues, but they need more support from VA Central Office to increase the salaries for all Nursing Employees. Also give the employees Saturday premiums and promote head nurse salaries so they can receive proper pay for being a supervisor like all supervisors in the Coatesville VA Medical Center system. These changes would create a situation that the Coatesville VA would have the best RN's running nursing service.

Attorney Murphy if you could resolve any of these problems at the Coatesville VA Medical Center, we would be very pleased. Our Veterans would then be receiving quality care from the employees. Anything less than this is not fair to our Veterans, they deserve #1 quality care.

I am enclosing an article from the American Nurses, May 1989 issue, in regards to the problems that Nursing Service has been experiencing nationwide in the VA System.

Sincerely,

Mark D. Bailey

MARK D. BAILEY
President, NAGE R3-35

Attachment: 1

National Federation of Federal Employees

James M. Peirce • President
Ronald W. Kipke • Secretary Treasurer

In reply refer to: ____________

June 5, 1989

The Honorable Alan Cranston
Chairman, Senate Committee on Veterans' Affairs
414 Russell Senate Office Building
Washington, D.C. 20510

Dear Chairman Cranston:

On behalf of the National Federation of Federal Employees, I am happy to respond to the additional questions from the Veterans' Affairs Committee following the May 18th hearing on health-care legislation. I would also like to take this opportunity to re-emphasize NFFE's appreciation for the Committee's extensive efforts to provide a solution to the recruitment and retention problems facing VA health-care personnel.

If S. 947 could be changed to include a significant role for employee representatives in the proposed competitive wage survey, NFFE would be able to support the legislation. We look forward to working with the Committee on this legislation, and trust that together, we will be able to solve many of the current problems for VA employees.

Question 1 - Is NFFE aware of any instances where low morale has occurred as a result of differing pay rates?

In speaking to NFFE members at VA facilities across the country, we are aware of morale problems in Fargo, ND, where employees' salaries compare unfavorably with Minneapolis, MN, and also in Amarillo, TX where salaries are lower than in California. Different morale problems exist in Northport, NY where employees' employment histories were reconstructed and 147 of the 289 nurses surveyed lost between three and five steps.

Morale problems arise at many facilites when some positions are surveyed for special rate increases and others are not. Some employees are concerned that while actual salary comparisons with non-VA hospitals may be precise, the surveys do not reflect the lower staffing levels and added responsibilites at the VA facilities.

1016 16th Street, NW; Washington, D.C. 20036; Phone: (202) 862-4400

NFFE National Vice Presidents:
Region 1, Georgiana Kachura, Huntington, NY
Region 2, Robert W. Simmons, Newark, NJ
Region 3, A.B. Reynolds, Panama City, FL
Region 4, Vivian W. Greer, Shreveport, LA
Region 5, Arthur R. Guarriello, Jr., Santa Fe, NM
Region 6, James G. McDonald, Bishop, CA
Region 7, Douglas D. Wright, Missoula, MT
Region 8, Brenda K. Olstad, Moorhead, MN
Region 9, Sheila Velazco, Muncie, IN

Question 2 - Broken down by profession, please tell us how many registered nurses and other title 38 employees NFFE represents and at which medical centers they are employed.

Fargo, ND, NFFE Local 225

1 Registered Nurse, 15 Physicians, 49 Licensed Practical Nurses, 18 NAs, 2 Dentists, 1 Counseling Psychologist, 2 Physical Therapists, 4 Nurse Anesthetists

Northport, NY - NFFE Local 387

297 RNs, 4 MDs

Jackson, MS, NFFE Local 589

114 RN, 54 LPNs, 31 Nursing Assistants, 27 MDs, 1 Clinical Psychologist, 2 Nurse Anesthetists 1 Physician's Assistant.

East Orange, NJ, NFFE Locals 1154 and 1431

276 RNs, 72 LPNs, 179 NAs, 116 Physicians, 1 Counseling Psychologist, 11 Clinical Psychologists, 2 Podiatrists

Castle Point, NY, NFFE Local 346

150 RNs, 23 LPNs, 63 NAs, 28 MDs, 4 Counseling psychologists, 2 Dentists, 1 Physical Therapist, 2 Clinical Psychologist, 1 Nurse Anesthetist, 3 Physicians Assistants

Amarillo, TX - NFFE Locals 1138 and 1631

75 RNs, 25 LPNs, 9 NAs, 3 Physicians Assistants

Spokane, WA, NFFE Local 1641

81 RNs, 35 LPNs, 37 NAs, 16 MDs, 1 Dentist, 2 Physical Therapists, 1 Clinical Psychologist, 1 Nurse Anesthetist, 2 Physicians Assistants

Leavenworth, KS, NFFE Local 1765

105 RNs, 25 MDs, 4 Dentists, 2 Physical Therapists, 1 Nurse Anesthetist, 1 Podiatrist.

Martinsburg, WV, NFFE Local 1798

1 RN, 38 MDs, 2 Counseling Psychologists, 2 Dentists, 1 Optometrist, 1 Physical Therapist, 3 Clinical Psychologists, 11 Physicians Assistants, 1 Podiatrist

New Orleans, LA, NFFE Local 1904

206 RNs, 237 MDs 2 Counseling Psychologists, 6 Dentists, 2 Occupational Therapists, 5 Clinical Psychologists, 7 Nurse Anesthetists 5 Physicians Assistants 1 Podiatrist.

Shreveport, LA, NFFE Local 1956

160 RNs

Question 3 - What is NFFE's understanding of the complexity of the process currently used to determine special rates, and what does NFFE mean by a "mini survey"?

While NFFE does not participate in the special rate survey process and therefore is unable to comment on the precision of individual surveys, we are aware that the usefulness in terms of solving recruitment and retention problems varies by facility and appears heavily dependent on the interest of individual VA Administrators.

Some NFFE Locals are concerned that their VA facilities do not obtain accurate salary information from competing hospitals, either because those involved in the survey at the VA are not sufficiently skilled, or because the non-VA hospitals are competing for the same employees and have no incentive to cooperate in the survey.

Some NFFE VA Locals fear that their Personnel Office employees, who survey for only a portion of the nurses now, would not be able to cope with annual surveys for all the health-care employees.

The reference to "mini-surveys" in NFFE's testimony was intended to characterize a survey for only some of the Title 38 employees, rather than one that encompasses all the affected workers. The difficulties of matching not only position descriptions, but also shifts and responsibility levels in any such survey could be greatly alleviated through the participation of employee representatives who would likely be much more familiar with actual working conditions than many personnel specialists.

I hope you find this information to be useful. Please do not hestiate to contact NFFE Legislative Director Beth Moten (862-4445) with any questions.

Sincerely,

James M Peirce

James M. Peirce
President

PVA

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

June 6, 1989

The Honorable Alan Cranston, Chairman
Senate Committee on Veterans' Affairs
SR-414, Russell Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

Attached are the responses to the questions on procreative services in follow-up to the May 8, 1989, hearing of the Senate Veterans' Affairs Committee.

Sincerely,

Douglas K. Vollmer

Douglas K. Vollmer
National Legislative Director

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300 Fax: (202) 785-4452

1. I appreciate your kind words about our successful efforts on the budget resolution and your support for our efforts.

2. On procreative services, VA has raised questions on page 6 of its testimony relating to the number of times each couple should be provided services, whether services should be extended to pre- and postnatal services and the delivery itself, and whether services should be provided to couples who have a high likelihood of producing a retarded or disabled child? Could you please review and comment on these VA concerns?

The questions the Department of Veterans Affairs raised regarding various aspects of the provision of procreative services for eligible veterans are important, but not unaccountable, in each instance.

The Department raised concerns over the number of times each couple should be provided services in order to achieve pregnancy. Paralyzed Veterans of America (PVA) does not believe that any regulated limit be placed on the number of times these services could be provided. We do not believe that the Congress or the DVA should be in the position to limit treatment based on an arbitrary statutory or regulatory number of procedures when there exists any reasonable medical or scientific evidence that the veteran and spouse have any realistic opportunity to conceive a child or even several children over a period of years. This must be a medical decision, determined within the bounds of the patient/physician relationship and based on the best available information on the health and physical condition of the parents and the status of reproductive medicine. To arbitrarily limit by statute or regulation, the number of procedures, and hence, the number of children a disabled veteran might have, would seem to raise many ethical questions the Department has stated in previous testimony it would like to avoid.

Independently, a couple or an individual suffering from procreative dysfunction has no real limit to the number of times they could undergo a procreative medical procedure. In many instances, all they would need is a willing physician and sufficient resources. However, to continue to provide any medical treatment or service when their is no rational medical evidence of positive outcome, or when there appears to be no credible consensus that the procedure could be beneficial, boarders on the unscrupulous. Such a situation could present a persistent danger to the patient under any circumstance. Limits should only be prescribed within the bounds of the patient/physician relationship and should be the sole responsibility of those two parties.

For the most part, the DVA currently does not have the expertise to provide the broad array of specialized medical services required to meet the fertility needs of all disabled male and female veterans. In this instance, we envision the vast amount of treatment to be provided by non-VA health professionals on a fee basis status. The DVA would, of course be responsible to establish basic eligibility and basic need for the services. The Department would also be responsible to determine if the veteran is a proper candidate for such procedures, or whether, based on proper medical consultation there remains little or no chance that any fertility treatment would be efficacious.

Once such a determination has been made, the DVA, as in similar fee basis arrangements, would refer the veteran to an approved list of contract physicians or clinics. The VA's role in this process should end at that point. The DVA would now become primarily a third party payor and have limited liability for the actual treatment provided or the eventual outcome of conception, pregnancy and birth. The decision as to what procedures to utilize, within the boundaries of the authorizing legislation, should be determined solely within the context of the patient/physician relationship. If the physician finds the veteran, for whatever reason to be an unsuitable candidate for procreative services at any point in this process, naturally it would be his or her responsibility to so inform the veteran patient and the Department. Likewise, any liability for injury to the patient or the fetus would rest, as is the case now, with the physician provider, not the Department of Veterans Affairs.

We do not envision or expect that the Department should have any responsibility either legal or financial once the basic referral process has been completed. Both pre-natal and post-natal care would be the sole responsibility of the veteran.

Physicians, by the very nature of their profession, willingly make and are empowered to make difficult ethical decisions on a daily basis - decisions involving both life and death. If the Chief Medical Director of the Department of Veterans Affairs with the considerable resources at his disposal, and with the best advice of his own physicians, is unable to review individual cases to determine eligibility, and set reasonable standards to determine the efficacy or propriety of certain medical procedures regarding procreation, then he should receive assistance.

Paralyzed Veterans of America suggests that legislation authorizing procreative services should be amended to include the establishment of a "Chief Medical Director's Advisory Committee On Procreative Services." The members of this Committee should be appointed by the Secretary of Veterans Affairs at the advice of the Chief Medical Director from the ranks of the most noted scientists and medical practitioners in the field of reproductive medicine. The advisory committee should be established to perform three basic functions:

1. To draft and recommend to the Chief Medical Director guidelines, criteria and standards for the provision of procreative services to eligible veterans by contract or contractors in order to maintain the highest standards of medical practice and successful outcome.

2. To regularly review the state of the art of fertility treatment and services to update these guidelines in accordance with accepted medical practice.

3. To serve in an advisory capacity to the Chief Medical Director as a peer review panel for individual veteran cases. The Committee would provide in those instances where the Department could be challenged by a veteran to provide services which could be unwise, redundant or ineffectual, an independent expert opinion and recommendation to assist the Chief Medical Director in making his determination.

The
American
Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

June 1, 1989

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Senator Cranston:

This is in response to your May 24, 1989 letter regarding questions in follow-up to the Committee's May 18, health care legislation hearing and comments on sections 1-6 and 8 of S. 1004.

Responses to the follow-up questions are enclosed.

With respect to S. 1004, section 2 would amend section 620(a)(2) of title 38, United States Code, to provide that the cost of nursing home care to eligible veterans in a non-VA facility will not exceed 45 percent of the cost of care in a VA general hospital in the state in which the non-VA nursing home is located, as determined annually by the Secretary of Veterans Affairs. In Alaska and Hawaii, the cost of such nursing home care will not exceed 50 percent of the cost of VA contract care in a community general hospital utilized by VA in those states, as determined annually by the Secretary.

It would allow VA to utilize a higher hospital cost index rate to reflect the higher cost of nursing home care in certain states, in particular Alaska and Hawaii where VA has no nursing home facilities. The American Legion views this proposal as necessary in order to assure the continued availability of contract nursing home care in those states where the overall cost of medical and nursing home care is high.

Section 3 of this bill would amend section 628(a)(2)(d) of title 38, United States Code, to clarify that all participants in VA vocational rehabilitation programs are authorized emergency medical care if a VA or other Federal medical facility is not reasonably available to provide the needed care.

The VA has the authority to pay for emergency medical services for veterans participating in a vocational rehabilitation program under 38 USC, Chapter 31. However, since section 628 of title 38 was first enacted, changes have been made in the VA's vocational rehabilitation programs. Today, veterans may be enrolled in an independent living course of training which may not involve a specific vocational goal or they may have completed a course of training but not as yet obtained employment. This provision would authorize emergency medical care to all veterans enrolled in vocational rehabilitation programs. In light of the expanded nature of the current vocational rehabilitation program, we believe this measure would provide necessary medical care protection to individuals aiming to acquire a measure of self-sufficiency and to those in the final stage of their program. We therefore support the intent of this measure.

Section 4 of the bill would amend section 4107(b)(2) of title 38, United States Code, to authorize VA to use the Director grade in the "Physician and Dentist Schedule" in section 4107(b)(1) for a physician or dentist in the Central Office of the VHS&RA whose position is comparable to the position of Director of a Department medical center, domiciliary, or independent outpatient clinic.

We believe that certain high level physician and dentist positions within the Central Office of the Veterans Health Services and Research Administration should be compensated in line with their functional and administrative responsibilities. The purpose being to improve the administration of physician and dentist assignments and advancements. The American Legion would offer no objection to this proposal.

Section 5 of this bill would amend section 4114(a)(3)(A) of title 38, United States Code, to authorize the temporary full-time appointment of graduate health-care personnel for more than one year, subject to a maximum of two years, provided they have successfully completed a full course of training in a recognized school for that occupation, approved by the Secretary and are awaiting licensure in a state or certification by a board recognized by the Secretary. In addition the proposed change would permit the VA to offer such graduates the opportunity to obtain health and life insurance.

Section 5 of the bill would also authorize the VA to reappoint physical therapy, occupational therapy and pharmacy students for a period not to exceed the duration of their academic program by amending section 4114(a)(3)(C) of title 38, United States Code.

We believe the provisions contained in section 5 of this bill are intended to improve VA's ability to recruit and retain certain health-care professionals. These provisions address troublesome situations and, as proposed, would allow VA to be more competitive in these areas. We are well aware of the difficulty VA has in recruiting and retaining physical and occupational therapists as well as pharmacists. Such incremental steps are necessary to measurably improve this situation. We fully support all measures which help to restore the image of the VA as a leader in these professions.

Section 6 of the bill would amend section 4205 of title 38, United States Code, to clarify that monies in the Veterans Canteen Service (VCS) revolving fund may be invested in Treasury securities. Current law provides that designated amounts from the VCS revolving fund may be deposited "in checking accounts or other interest bearing accounts." The proposed amendment is intended to clarify existing statutes.

The American Legion has no objection to the existing statute with respect to VCS investment practices, nor do we have any objection to the amendatory clause.

Section 8 of the bill would amend section 115 of Public Law 100-322 to extend for three years from September 30, 1989 to September 30, 1992, the VA's authority to provide community-based care for homeless chronically mentally ill veterans.

Based on established pilot programs for homeless chronically mentally ill veterans which have proved successful, we support the extension of the VA's authority to provide this pilot community-based care for an additional three years.

Sincerely,

R. S. Christian

RICHARD S. CHRISTIAN
Deputy Director
National Veterans Affairs and
Rehabilitation Commission

Enclosure

1. Q. You state on page 13 of your testimony that "there is a need for further clarification of the intent" of the dependent care provision of S. 947 and recommend that a study be conducted on the feasibility of it. How should such a study be structured and what information do you believe it would reveal?

A. Section 201 of S. 947 would require the Secretary to establish and operate for VHS & RA employees a dependent care assistance program which meets the requirements of section 129 of title 26, United States Code. The provision permits employees to contribute up to $5,000 annually tax-free for the care of the employee's dependents. Subsequent to the May 18 hearing, additional information was received and we have no objection to the intent of this measure. The bill is intended to provide an additional employee benefit to enhance recruitment and retention. Such programs for providing dependent care are found in the private sector. The provision offers certain additional advantages to VA employees.

2. Q. On procreative services, VA has raised questions on page 6 of its testimony relating to the number of times each couple should be provided services, whether services should be extended to pre and postnatal services and the delivery itself, and whether services should be provided to couples who have a high likelihood of producing a retarded or disabled child? Could you please review and comment on these VA concerns?

A. The vast majority of those eligible individuals who would utilize VA provided procreative services are Vietnam veterans who, without the application of special procedures to overcome the service-connected impairment of their procreative ability, would not be able to parent natural children. We further believe there are a relatively limited number of veterans who would be eligible for these services and an even smaller number who would avail themselves of them. In the event the VA does not provide this service to veterans, who will? We continue to support the intent of this measure.

Vietnam Veterans of America, Inc
2001 S St., NW
Suite 700
Washington, DC 20009-1125

(202) 332-2700

June 2, 1989

Senator Alan Cranston, Chairman
Senate Veterans Affairs Committee
SR-414 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Cranston:

We are pleased to respond to your letter of May 24, 1989 regarding the May 18, 1989 health-care legislation hearings.

Generally, as a rule, we do not want to micro manage the DVA. This position, in part, will be prevailing along with what we believe will truly be in the best interest of the veteran patient.

Regarding Section 211 of S. 13, which would require the DVA to furnish procreative services to service-connected disabled veterans or their spouses, VVA supports the measure. Regarding the issues the DVA has raised on the same subject in their testimony, there are many questions to be answered.

However, we feel that there is an obligation to the service-connected veteran to provide the service and that therefore, the necessary efforts for authorizing procreative services should be made.

Regarding S. 1004, Sec. 2. Section 620(a)(2), and Sec. 3. Section 628(a)(2), VVA supports the recommended changes as long as such changes are not adversely restrictive. We note in your letter that S. 1004 was introduced "at the request of the Administration." While all legislative proposals of the DVA may not adversely effect the veteran, our experience is that "the Administration," - especially OMB tend to subordinate the interests of the veteran to their own political and budgetary needs. It is our sincere hope that you and all the VSO's will be forever vigilant in this matter as all hands on deck are needed.

Regarding S. 1004, Sec. 4 Section 4107(b)(2), there is no "comparable" position in DVACO. DM&S Administrators at the medical center level are at least indirectly involved in direct patient care while DM&S Administrators (for example, Clinical Directors) appear to be involved in clinical policy for the agency and beyond. The proposal implies transferability or interchangeability between DVACO administrative clinical staff and medical center administrative clinical staff which is probably in the interest of quality patient care, not acceptable.

★ A not-for-profit national veterans' service organization ★

In any event, it is not appropriate for us to support this segment of the Bill as revised at this time.

Regarding S. 1004, Sec. 5. Section 4114(a)(3), VVA sees value in obtaining health insurance for employees who exceed one year temporary appointments. Additionally, we recognize that extending "temporary fulltime appointments of persons who have successfully completed a full course of training as a physical therapist, practical/vocational nurse, occupational therapist or pharmacist in a recognized school for that occupation, approved by the Secretary, and who are pending registration/licensure in a State or certification by a national board recognized by the Secretary" up to two years may positively effect recruitment efforts in DM&S.

However, VVA needs to be assured that such legislative actions will not result in the reduction of the ability in such staff to provide a quality product of care for the veteran. Specifically, DVA need not carry a larger percentage of unlicensed personnel for a longer length of time than allowed in the private professional sector in order to meet or say it has achieved staffing levels. Such a practice could not only end up taking advantage of such pre-licensed staff, but hurt the veteran patient.

It is our sincere hope that these recommendations, comments, and responses to your questions will be helpful to you.

Sincerely,

Thomas A. Sherwood,
Director for Health Policy
& Planning

Office of the
Administrator
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Washington DC 20420

Veterans
Administration

JUN 21 1989

Honorable Alan Cranston
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed please find the Department's response to a question raised by Senator George J. Mitchell following the May 18, 1989, hearing on health-care legislation. A copy of the response has been provided for Senator Mitchell.

Sincerely yours,

Anthony J. Principi
Deputy Secretary

Enclosure

cc: Senator George J. Mitchell

SENATOR MITCHELL

Question: One of the reasons for my personal interest in the health-care personnel recruitment and retention problems being experienced by VA is the continuing difficulties in this regard facing the Togus Medical Center. I think Senator Cranston's legislation addresses these problems in a very meaningful way; a way that will allow VA to correct its current problem.

Let me use two requests for special salary rates recently submitted, by Togus management as examples.

The first request, for special salary rates for Practical Nurses (LPN) states that Togus, ". . . is finding that mere salary is often not the deciding factor in recruiting and retaining LPNs. Health, dental, and long-term disability insurance are the most frequently mentioned benefits where private industry, in most cases, outperforms government."

This consideration of benefits other than salary would, under the Chairman's legislation, have to be taken into consideration by center directors in doing their annual salary surveys.

The second request for special salary rates recently submitted by Togus management is for an entire 10-step special salary rate for Junior, Associate, Full and Intermediate grade Registered Nurses (RN). The request says, "Advanced in-hire rates may help recruitment efforts but add to our retention problems as our experienced nursing work force sees salary compression with new recruits at starting salaries often equal to theirs. This serious moral issue can be eliminated by approving a 10-step pay range for each grade."

Again, this consideration of salary compression is squarely addressed in the Chairman's legislation.

Aside from the arguments in favor of the Chairman's legislation, can you tell me the status of these two special salary requests for the Togus Medical Center and give me your estimate of when they will be approved or disapproved. I strongly urge you to approve these requests, if you have not already done so.

Answer: We have completed review of the two special salary rate requests from the Togus VA Medical and Regional Office Center and have approved the request for an entire 10-step special salary rate for Junior, Associate, Full and Intermediate grade Registered Nurses (RNs). However, the special salary rate range requested for Practical Nurses (LPNs) for grades GS-3, GS-4, GS-5, and GS-6 was not approved because the existing rates exceeded the community average rates.

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI TO THE DEPARTMENT OF VETERANS AFFAIRS AND THE RESPONSES

Question: 1. I am pleased that VA is supportive of my legislation to expand VA's third party reimbursement program. VA proposes to modify my bill by authorizing VA to retain 50 percent of the funds collected by third party payers.

1A. I understand that in the past VA has not supported the concept of VA retaining these funds. What has happened to change VA's position?

Answer: VA has changed its position since it now believes that retention of these collections by medical centers would provide a needed incentive to enhance third party collections.

Question: 1B. It has been said by the Chief Medical Director that OMB has made it clear that the President's budget request for VA will be reduced by the amount expected to be collected under this program. Is this your understanding of OMB's position? If not, when did OMB's position on this issue change? And how can you be assured that it did?

Answer: OMB has indicated that it may consider allowing VA to retain a portion of the collections without offset if OMB could receive a guarantee from VA that the funds would be used to either contract for collection services or to fund dedicated FTEE for the third party collection program.

Question: 1C. Does the VA also propose to modify current law to authorize VA to retain 50 percent of the funds collected from nonservice-connected veterans?

Answer: At this time, VA is only proposing to retain 50 percent of the collections to be generated by this bill; i.e., funds recovered from health insurance policies covering service-connected veterans when they are treated for their nonservice-connected disabilities. It should be noted that no collections are made directly from veterans under this program, only from their insurance policies. As we continue to study our experience with the program, we will in the future recommend legislative improvements that we believe would enhance its operation.

Question: 2. On Page 4 of VA's written testimony, it is stated that VA will withhold endorsement of assistive animal legislation until VA has completed its evaluation of the program.

2A. When will that evaluation be complete?

Answer: The evaluation conducted by the Rehabilitation Research and Development Evaluation Unit has been completed and is now under review in the Department of Veterans Affairs. We expect to complete our review by the end of June 1989.

Question: 2B. In light of the interest by both the Chairman and myself on this issue, will the Committee receive a copy of that evaluation together with VA's views on legislation in this area?

Answer: Yes.

Question: **2C. If so, when can we expect to receive that information from the VA?**

Answer: The VA will provide the report by the end of June 1989.

Question: **2D. If the evaluation is positive and VA supports the concept of providing these animals to veterans, will VA provide funding support to the organization known as "Helping Hands, Simian Aides for the Disabled, Inc."?**

Answer: Assuming that authorizing legislation is enacted thereby enabling VA to provide such animals to veterans, VA will, based on diagnoses, clinical indicators, and by medical prescription provide a quadriplegic veteran patient a trained simian aid. Such animals would be procured through the normal contractual process in which "Helping Hands" will be able to bid along with others, if any, for a contract as one vendor/manufacturer providing medical devices. If awarded a contract, "Helping Hands" would be expected to deliver to VA a fully trained animal and all necessary support services to ensure that the animal is integrated successfully into the veteran's home. "Helping Hands" would also be expected to provide appropriate and necessary follow-up services. The research, development and evaluation phases of this project are completed and no further VA funding will be provided for such purposes. In the future, "Helping Hands" would be considered as a commercial supplier providing medically prescribed devices to eligible veteran patients.

Question: 3. VA recommends in its written testimony that the committee hold off on recruitment and retention legislation until the Task Force completes its work and VA reviews their recommendations.

3A. When can we expect this to happen and when will the Committee be informed of specific proposals in this area?

Answer: We are currently analyzing a final report on the Study of Pay and Other Personnel Management Practices. This study, which was mandated by Public Law 100-322, was recently completed and covers employment trends, wages and wage compression, shift differentials, and benefits. It is anticipated that the analyses of this report and the VA Task Force recommendations on nurse pay will be completed by the end of June. We plan to transmit our proposed legislation to the Committee by September 1.

Question: 4. The competitive pay provision for VA nurses contained in Section 101 of S. 947 would require VA to pay competitive salaries for registered nurses and certain other nurses.

4A. What is VA's cost estimate of this provision?

Answer: Our 5-year cost estimate (in millions) is as follows:

FY	Section 101(a)	Section 101(e)
89	$ 0	$0.65
90	$ 8.93	$4.84
91	$ 35.72	$0
92	$ 35.72	$0
93	$ 35.72	$0
TOTAL	$116.09	$5.49

Question: 4B. What impact do you believe this provision would have?

Answer: Section 101 of S. 947 would require the VA to pay competitive salaries based on local market conditions. The VA continues to use special salary rates in an effort to remain competitive. Local wage surveying is now done as part of the process for determining the special salary rates, and experience shows that staying aware, on a systematic basis, of rates competing employers pay does have a positive impact on our ability to recruit and retain these health care professionals. As discussed during the hearing, we are continuing to review options to determine how best to meet our nurse manpower needs. During this process, we will assess the impact of S. 947 and other proposals that have been made.

Question: 4C. Medical Center Directors told the Committee last year that they simply can't afford to implement more Congressionally mandated program requirements without additional funds.

Do you believe that the competitive pay proposal would have a negative impact on VA facilities because it would require competitive pay without providing appropriations to pay for that requirement?

Answer: The comments made by the facility Directors remain valid. Without an adequate level of funding in both this fiscal year and FY 1990, VHS&RA will be unable to undertake any more unfunded, Congressionally mandated program requirements without harming both quality and quantity of care delivered.

Question: 5. Ms. Ferguson stated during the hearing that workload contributed to nurses dissatisfaction with their jobs and that paperwork accounted for a large amount of the nurses work.

5A. In that regard, what is the status of the nursing application for the Decentralized Hospital Computer Program (DHCP)?

Answer: The nursing DHCP package "version 1.4" was verified and released to the field in September 1988. It automated nursing administration, nursing education, and patient classification information. "Version 2" which is scheduled to be released the first quarter of FY 1990 will include the automation of nursing workload data and clinical data, e.g., nursing care plans and patient admission data base.

Question: 5B. How many, if any, VA facilities currently have operational the nursing software package?

Answer: As of April 1989, sixty-five sites or 40% of VAMCs have the nursing software package "version 1.1 or 1.4," in production. Nursing is part of the enhanced core software and some VAMCs do not yet have sufficient computer equipment to put enhanced core software on-line.

Question: 5C. Has that application reduced the amount of administrative/charting tasks required of nurses?

Answer: Nursing software package "version 1.1 or 1.4" has not appreciably reduced the amount of administrative/charting tasks required of nurses. "Version 2" of the nursing software package should substantially decrease the amount of time nurses spend writing nursing care plans and the patient admission data base.

To further improve nurses' time for direct clinical care and to significantly reduce nursing paperwork, an automated order entry/results reporting (OE/RR) system is being implemented. Nursing Service's first priority for automation remains OE/RR. Currently, Phase I of OE/RR is being tested and general release is expected later this summer. Phase I includes standard ordering for inpatient pharmacy, laboratory, dietetics, nursing vital signs/measurement, and MAS transfers/discharges.